2016

MO HealthNet Managed Care Program

External Quality Review

Report of Findings

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1.0 EXECUTIVE SUMMARY

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I.1 Introduction

The United States Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Managed Care Health Plans (MCHPs) and their contractors to participants of Managed Care services. The CMS rule[1] specifies the requirements for evaluation of Medicaid Managed Care programs. These rules require a desk review as well as an on-site review of each MCHP.

The State of Missouri contracts with the following MCHPs represented in this report:

MCHP	**MCHP Parent Company**	**Date Contract Began**
Aetna Better Health of Missouri (Aetna Better Health)	Aetna, Inc.	September 1995
Home State Health	Centene Corporation	July 2012
Missouri Care	WellCare Health Plans, Inc.	March 1998

The EQR technical report analyzes and aggregates data from three mandatory EQR activities and one optional activity:

1) Validating Performance Improvement Projects (PIPs)[2]

2) Validation of Performance Measures[3]

3) Compliance with Medicaid Managed Care Regulations[4]

4) Optional Activity: Case Management Record Review

[1] 42 CFR §433 and §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations
[2] Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September 2012. Washington, D.C.: Author.
[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September 2012. Washington, D.C.: Author.
[4] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, D.C.: Author.

1.2 Validating Performance Improvement Projects

The focus of the PIPs is to study the effectiveness of clinical or non-clinical interventions. These projects should improve processes associated with healthcare outcomes. They are to be carried out over multiple re-measurement periods to measure: 1) improvement; 2) the need for continued improvement; or 3) stability in improvement because of an intervention. Under the MCHPs' contracts with the State of Missouri, each MCHP is required to have two active PIPs; one of them is clinical in nature, and the other one non-clinical.

After reviewing all MCHP PIP topics conducted during 2016, the final selection of PIPs to be validated during this review was made by MO HealthNet in February 2017. Improving Oral Health, a statewide PIP, was selected as the non-clinical PIP for all the MCHPs. Additionally, Improving Childhood Immunizations was chosen as the clinical PIP for all MCHPs.

The EQRO reviews each PIP to determine if it was designed, conducted, and reported in a methodologically sound manner. Specific feedback and technical assistance were provided to Missouri Care and Home State Health by the EQRO during on-site visits.

A list of all evaluated PIPs and summary of compliance is shown in Table 1.

Table 1- Summary Performance Improvement Validation Findings by MCHP.

PIP Title	Overall Rating
Aetna Better Health Improving Childhood Immunizations	100%
Aetna Better Health Improving Oral Health	100%
Home State Health Improving Immunization Rates in Home State Health Members in the First 2 Years of Life	81.82%
Home State Health Improving Oral Health	100%
Missouri Care Improving Childhood Immunization Status	66.67%
Missouri Care Improving Oral Health	95.45%

Note: This table is a summary of the data from Table 3 of this report, see Section 2.3.

Clinical PIPs

All three MCHPs developed PIPs to improve the number of children who receive childhood immunizations by age two, as defined in the HEDIS Combo 3 specifications. All three MCHPs presented well-developed study topics that provided a sound rationale for implementing a PIP addressing the improvement of the number of children who receive immunizations. The study topics provided information on the need for immunizations as a method to prevent early childhood illnesses, such as diphtheria, measles, meningitis, polio, tetanus, and whooping cough, at a time in children's' lives when they are most vulnerable to diseases. Additionally, the MCHPs provided convincing evidence that preventing outbreaks of serious and communicable diseases is valuable in communities.

Barriers to succeeding at improving the number of children receiving immunizations were presented for members, providers, and each MCHP. Interventions were developed to address these barriers. In the Calendar Year 2016 (CY 2016) review, all three MCHPs used their HEDIS rates as an "indicator" of the success of their interventions. The EQRO contends that the HEDIS rate is the outcome measure for any changes made. The MCHPs should develop specific indicators for each intervention to evaluate those which are successful and those which are unsuccessful.

The Childhood Immunization PIPs are new; and none of them has been in place for more than two years. Missouri Care and Home State Health both experienced a decrease in their HEDIS rates for the HEDIS Year 2017 (HY 2017). Aetna Better Health also showed a slight decline. However, the Aetna Better Health rate was an unaudited rate presented in March 2017 and did not include any Hybrid results. It is difficult to compare Aetna's efforts to other MCHPs as the MCHP closed at the end of April 2017.

Non-Clinical PIPs

All three MCHPs presented individualized non-clinical PIPs in response to the Statewide PIP concerning Improving Oral Health. The study topic presentation for each individual PIP used the information from the Statewide PIP as the foundation of their topic argument. Each MCHP added information about how this topic is pertinent to their members between the ages of two and through twenty. These topic presentations have been updated annually.

Each MCHP presented their interventions implemented in CY 2016. As in the clinical PIPs, these PIPs failed to measure individual interventions. The MCHPs HY 2017 rates either declined or remained steady. Both Missouri Care and Home State Health have experienced the same outcomes for at least two years.

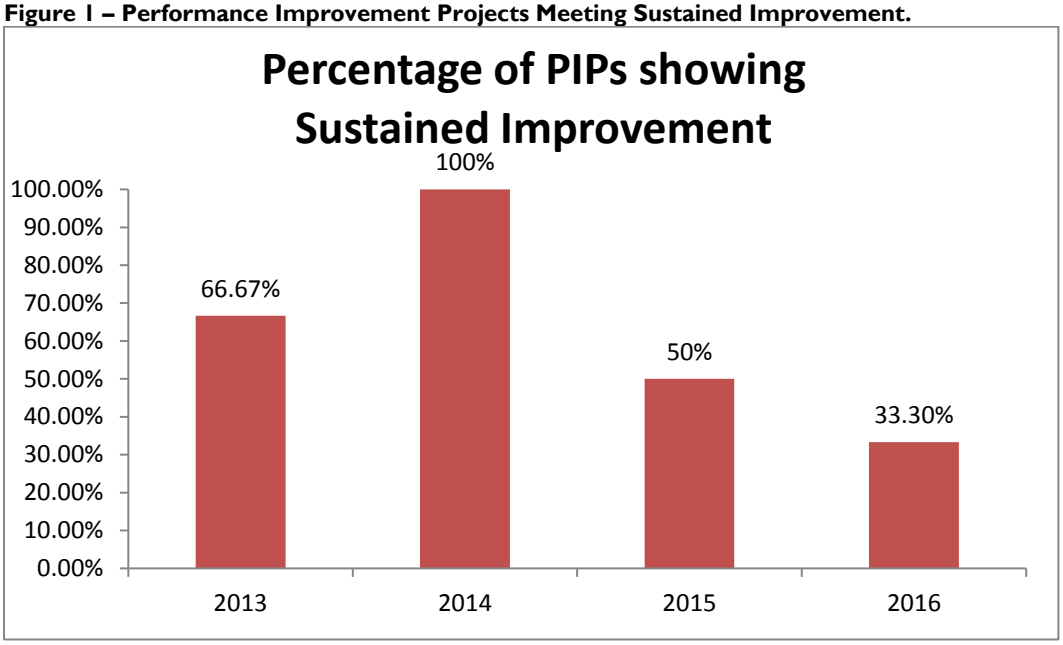
Interventions should be designed to produce measurable results enabling the MCHP to evaluate effectiveness. Using this methodology would allow the MCHPs to discontinue interventions that are not producing the desired results. The inability of the MCHPs to reach their stated goal of a three percent increase each year indicates that innovative approaches are needed.

CONCLUSIONS

The aggregate rating for meeting all the requirements of PIP Validation has increased substantially from the 25.1% rating received during the first year when PIPs were reviewed (2004). The rating of the 2016 review year was increased to 91.34%, an improvement from the 2015 rating of 86.89%. The MCHPs are using the PIP methodology to design studies that incorporate quality improvement principles to enhance members' services. A renewed focus by all MCHPs on implementation of new interventions each year would create an environment more likely to produce quality healthcare for members. This is an area where the MCHPs need continued development.

Figure 1 depicts an essential element of the validation of these projects; the projects' ability to create sustained improvement, or to produce repeated improvement over more than one measurement period. For this element, the EQRO assesses each PIP to determine if real change is the result of improvement in the fundamental processes of the MCHPs' health care delivery system; or if change is only a "one time" alteration that can be attributed to accidental occurrences or random chance.

Figure 1 – Performance Improvement Projects Meeting Sustained Improvement.



Source: BHC, Inc., 2013-2016 External Quality Review Performance Improvement Projects Validation.

In 2016, three PIPs were considered mature enough to be evaluated for sustained improvement. These were the Improving Oral Health PIPs. Aetna Better Health's PIP was determined to have reached sustained improvement in each of the last five years. Missouri Care's PIP was considered "Partially Met", as they were only able to achieve an improvement of 0.37 percentage points over the 2015 rate, and a total of 1.23 percentage points since 2014. Home State Health's PIP did not reach sustained improvement as the last two years showed a declining rate.

1.3 Validation of Performance Measures

The Validation of Performance Measures Reported by the MCO Protocol requires the validation or calculation of three performance measures at each MCHP by the EQRO. The measures selected for validation by MO HealthNet are required to be submitted by each MCHP on an annual basis. Any HEDIS measures were also submitted to the State Public Health Agency (SPHA; Missouri Department of Health and Senior Services; DHSS). For the 2016 evaluation period, the three performance measures selected for validation included:

1. HEDIS 2016 measure Prenatal and Postpartum Care (PPC);
2. Emergency Department Visits (EDV); and
3. Emergency Department Utilization (EDU).

The EQRO examined the information systems, detailed algorithms, MCHP extract files, medical records, and data submissions provided to the SPHA to conduct the validation activities of this protocol.

All the MCHPs use adequate information systems to capture and store enrollment, eligibility, and claims information for the calculation of the three measures validated. However, two MCHPs (Home State Health and Missouri Care) were unable to provide the information as requested from their information systems to enable the EQRO to recalculate the EDV and EDU measures consistently.

Among MCHPs, there was good documentation of the HEDIS 2016 rate production process. The rate of medical record submission for the one measure allowing the use of the hybrid methodology was 100%; and the EQRO received all the medical records requested. This review also marked the fourth review year in which all contracted MCHPs performed a hybrid review (involving the use of both administrative data (such as claims/encounter data) and medical record review) of the measure selected, allowing for a complete statewide comparison of those rates.

QUALITY OF CARE

This is the second year to audit the EDU measure. This measure serves to provide a count of the individual number of members who access the ED for various issues over the course of the measurement year. This measure provides further detail to the reason for the ED visit, categorizing it as Medical, Behavioral Health, or Substance Abuse. This information is useful for the MCHPs to determine if the ED is being utilized properly by its members. The MCHPs can also use this information to ensure that the quality of care necessary for members is available in the ED for the non-medical categories.

One MCHP (Aetna Better Health) received a rating of Substantially Compliant with the specifications for calculation of this measure. The EQRO is confident in the rates validated for Aetna Better Health's behavioral health, and substance abuse sub-measures, as these rates had an estimated bias of 0.02% or less. The EQRO is not confident in both the Home State Health and Missouri Care rates as neither MCHP's supplied data proved to be accurate.

Access to Care

The EDV measure is intended to measure the number of ED visits recorded for the MCHP. Members need only one qualifying visit from any appropriate provider to be included in this measure calculation. This measure provides further detail as to the reason for the ED visit, categorizing it as Medical, Behavioral Health, or Substance Abuse.

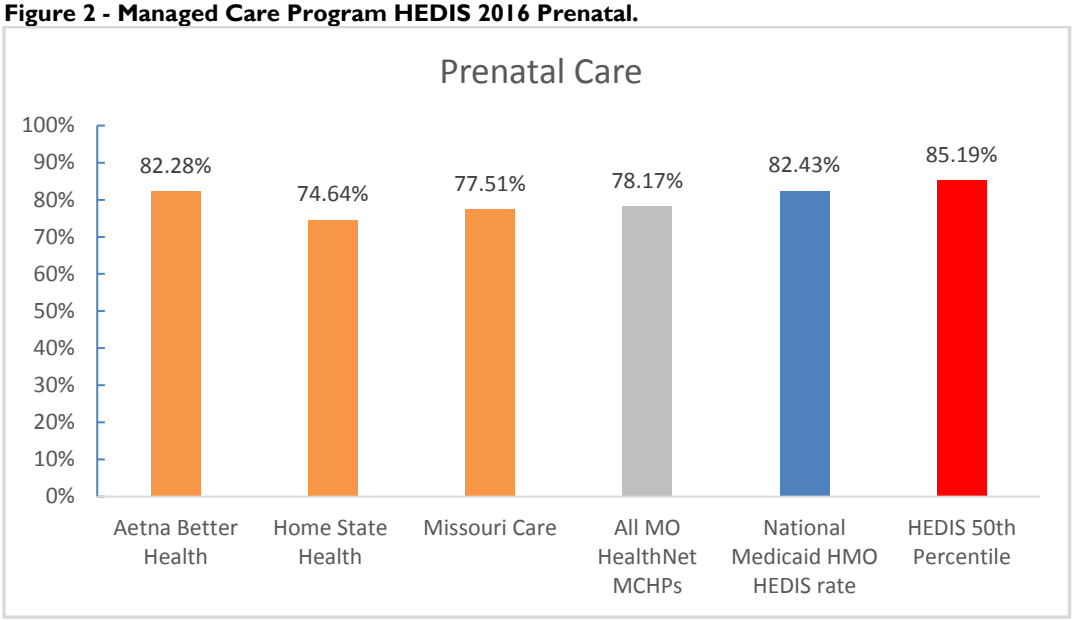
Two MCHPs (Home State Health and Missouri Care) had the EDV measure rated as Not Valid by the EQRO. This was the second year for a review and audit of the EDV measure. The data received from these MCHPs was recalculated and the EQRO was unable to produce the results that the MCHPs had reported to MO HealthNet. Aetna Better Health supplied records that were consistent with the measure specifications, and these records produced results that were in line with the reported number of hits.

Timeliness of Care

The HEDIS 2016 Prenatal and Postpartum measure is categorized as an Access/Availability of Care measure and aims to measure the access to and timeliness of the care received. To increase the rates for this measure, members must receive a visit within a specific timeframe (i.e., in the first trimester or between 21 and 56 days of delivery).

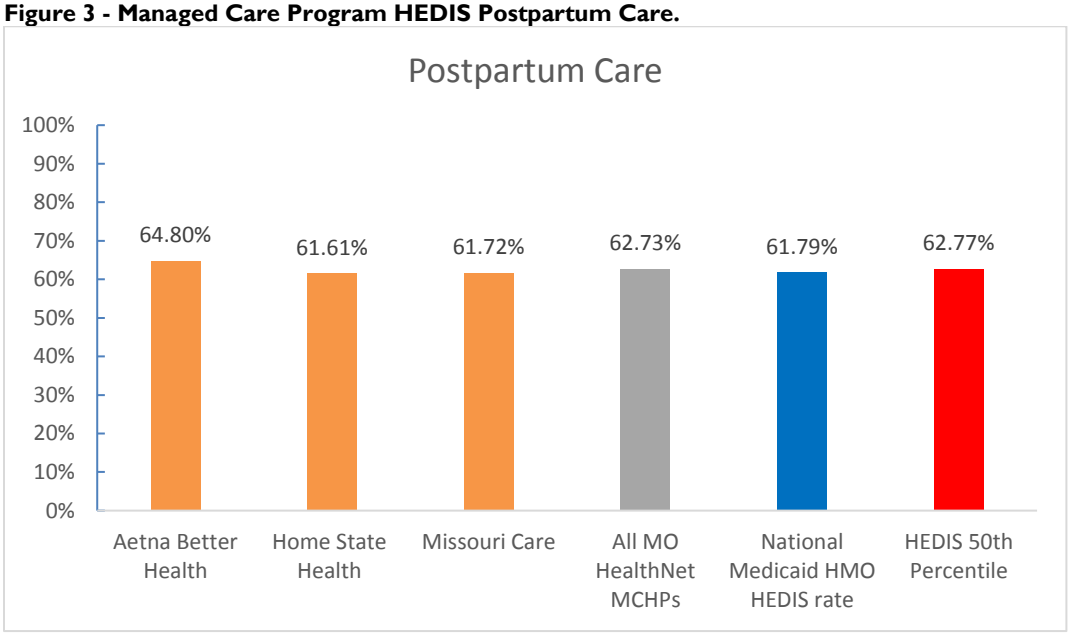
All three MCHPs validated by the EQRO were Fully Compliant with the specifications for calculation of this measure. The MCHPs were all consistent with or exceeded the National Medicaid Average of 61.79% for the Postpartum measure. However, all MCHPs fell short of the National Medicaid Average of 82.43% for the Prenatal measure. This was the first year that PPC had been audited since 2006.

Figure 2 - Managed Care Program HEDIS 2016 Prenatal.



Sources: MCHP HEDIS 2016 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Figure 3 - Managed Care Program HEDIS Postpartum Care.



Sources: MCHP HEDIS 2016 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

1.4 Compliance with Medicaid Managed Care Regulations

The purpose of the protocol to monitor MCHP Compliance with Managed Care Regulations is to provide an independent review of MCHP activities and assess the outcomes of timeliness and access to the services provided. The policy and practice in the operation of each MCHP was evaluated against the regulations related to operating a Medicaid managed care program. The regulations were grouped into three main categories: Enrollee Rights and Protections, Quality Assessment and Improvement, and Grievance Systems. The Quality Assessment and Improvement category was further subdivided into three subcategories: Access Standards, Structure and Operation Standards, and Measurement and Improvement. Initially, MO HealthNet reviewed each MCHP's policy to determine compliance with the requirements of the Managed Care Contract. These determinations and their application to the requirements of the federal regulations were assessed by the EQRO.

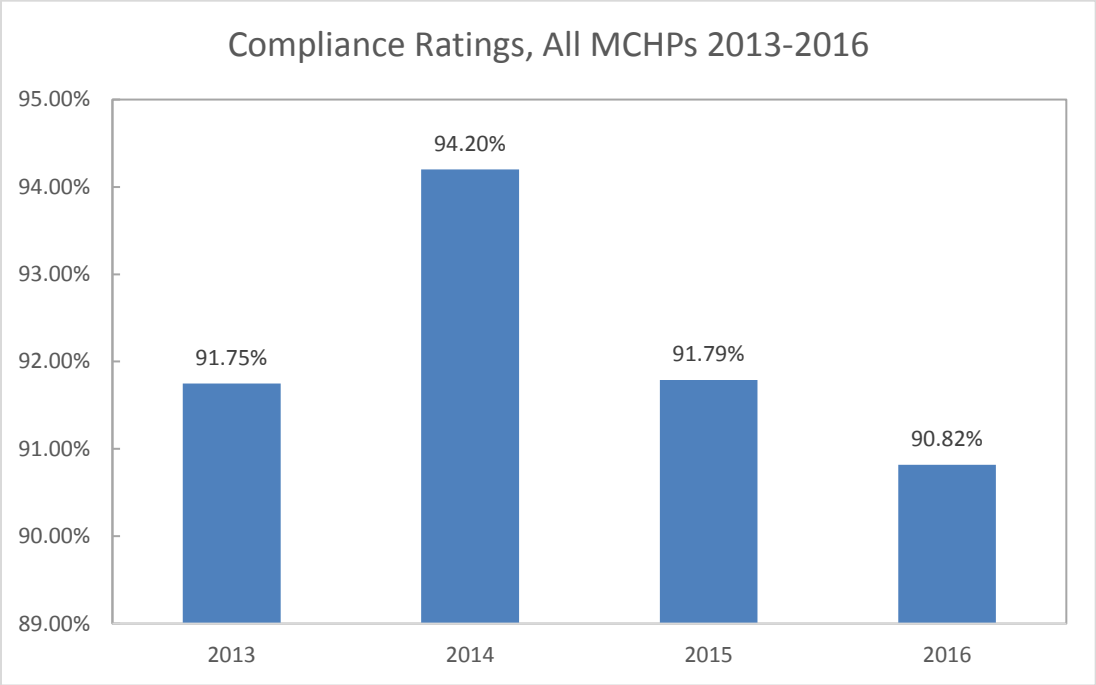
This year's review (calendar year 2016) is the first of two follow-up compliance reviews. The EQRO Compliance Review focused on implementation of policies and procedures. The review included a focus on Case Management, case record reviews, and interviews with Case Management and Administrative staff. The results of the Case Management review are reported in detail in Section 5.0 of this report as a "Special Project".

For the seventh consecutive year, none of the MCHPs could demonstrate 100% compliance with all requirements related to case management and care coordination.

Conclusions

Since the EQRO began reviewing compliance in 2004, the MCHPs have shown continuing improvement in their ability to meet the requirements of compliance with the federal regulations. Initially, the MCHPs did not have complete and approved written policies and procedures and their processes did not comply with contractual and regulatory requirements. However, in the 2016 review, the overall compliance rating was the lowest in the last four years.

Figure 4 – Summary of MCHP Compliance with Federal Regulations 2012-2016.



Source: BHC, Inc., 2012-2016, External Quality Review Compliance Validation.

All MCHPs were 100% compliant with three of the compliance areas validated during this review year. For the seventh year in a row, none of the three MCHPs were 100% compliant with all requirements, due in large part to the issues that the EQRO found in compliance with Case Management requirements and the Provider Availability study.

1.5 MO HealthNet MCHP Case Management Performance Review

In 2010, the EQRO began conducting a special project related to the provision of Case Management services by the MCHPs. The objective of this special project is to complete an in-depth follow-up review of Case Management by assessing the MCHPs' improvement in service delivery and record keeping. This involved the evaluation of the MCHPs' compliance with the federal regulations and the Managed Care contract as it pertained to Case Management.

The focus of this review was as follows:

- Assessing the MCHPs' attention to and performance in providing case management to:
  - Pregnant members;
  - Members with special health care needs; and

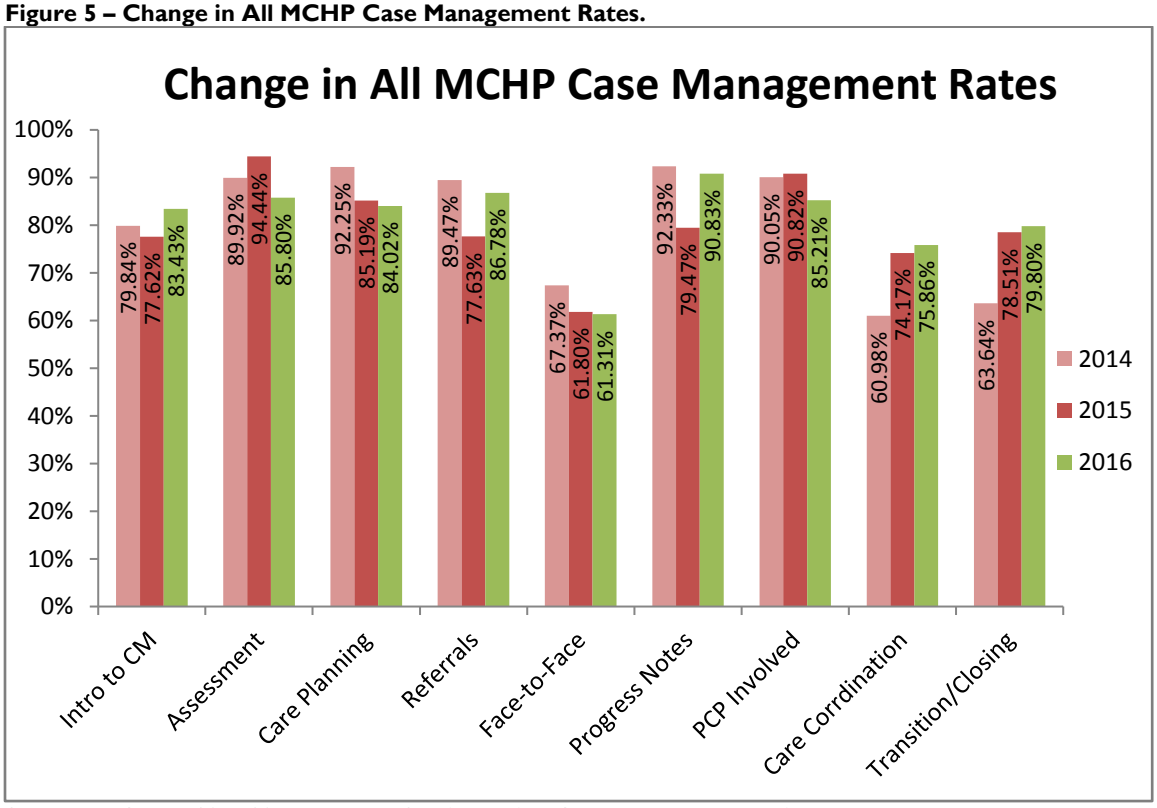
    - Children with elevated blood lead levels.
- Evaluating compliance with the case management requirements of MO HealthNet Managed Care contract; and
- Exploring the effectiveness of case management activities provided by the MCHPs on cases reported as open in each MCHP system.

There are nine categories for which each MCHP's Case Management program is evaluated. These contract categories include:

- Introduction to Case Management
- Assessment
- Care Planning
- Referrals
- Face-to-Face Contacts
- Progress Notes
- PCP Involvement
- Care Coordination
- Transition at Closing

The following figure depicts the change in Case Management ratings received for all MCHPs between 2014 and 2016.

Figure 5 – Change in All MCHP Case Management Rates.



Source: BHC, Inc., 2014-2016, External Quality Review Case Management Review.

The review of Aetna Better Health case management was based solely on record review due to the closure of this MCHP. Aetna Better Health was improved in two of the nine areas measured (Making referrals for face-to-face contacts and inclusion of required progress notes). Aetna Better Health has not created new or innovative approaches in their case management program for several years. The declining numbers observed during 2016 indicate that case management was not receiving the attention necessary for achieving improved results. Serious deficiencies were found in the areas of complete and comprehensive assessments, care planning, primary care physician (PCP) involvement, and behavioral health referrals.

The review of case management records, and the subsequent interviews with case managers from Missouri Care and Home State Health provided information on the state of case management at the MCHPs.

Missouri Care improved in five of the nine areas measured in this review (initial member contact and introduction to case management, cases with assessments, making appropriate referrals for medical and community based needs, inclusion of progress notes, and creating a rapport with

members). Missouri Care has initiated innovative interventions such as providing in-home case management in the Eastern Region. Referrals for in-home case management from Missouri Care Case Managers can be made for members within 60 miles of St. Louis. Information from these case managers reflected improved communications and direct services to members.

Home State Health improved in eight of the nine areas measured in this review. The only category that did not show improvement was developing comprehensive assessments. Assessments were found in 96.61% of Home State Health cases, which reflects two cases reviewed with no evidence of an assessment. No specific problems were identified, and it is likely that the assessment tools were not included in the information submitted to the EQRO for review.

Home State Health's case management program has continued to develop since their first EQR review in 2012. In past reviews, the EQRO found that employees from different levels, including multiple case managers, were contacting members, as part of their case management services. The EQRO expressed concern about how this might confuse members, precipitating a failure of the case manager to develop a relationship with the member. During the on-site review, the case managers explained that their model has been changed; and now one case manager was working with each member. The case managers expressed their opinion that this change has assisted them in the identification of members' service needs, and has ensured that those needs were met.

CONCLUSION

When members are properly introduced to and engaged in case management, the quality of service delivery improves. For example, case managers were able to maintain contact with the members they served throughout the case management process. Case record reviews and interviews substantiated that, in some cases, the case managers advocated for extraordinary services to meet a member's healthcare needs.

The EQRO observed that Aetna Better Health had declining rates during 2016. This decline indicates that requirements of the case management program, based on the MO HealthNet contract requirements and federal regulations, did not receive the attention necessary to achieve improved results.

Missouri Care improved in the provision of case management; but they continue to leave room for improvement. Missouri Care has initiated innovative interventions such as in-home case management, which indicates a commitment to providing quality services to members. Missouri Care partners with the Children's Mercy Pediatric Care Network (PCN) in the Western Region. The PCN cases continue to exhibit a high standard of care.

Home State Health remains committed to improving their case management program and to developing quality member services. Home State Health made a strong effort to locate and introduce case management to members in need. It should be noted that Home State Health case managers reached members in 100% of their lead cases to introduce and offer case management. Provision of effective lead case management services has been a problem in previous years for all three MCHPs. Home State Health's records and case managers exhibit a strong commitment to the lead case management program, equal to other areas of case management.

When case managers are actively serving a member, fewer emergency department visits occur, members attend scheduled appointments, and assistance is provided to ensure that members see specialists in a timely fashion. In the OB cases reviewed, where there was evidence of active case management, follow-up visits with the OB, and initial pediatrician appointments for the newborn occurred within specified time frames. Parents who received these services often enrolled their babies with the MCHP; and ongoing preventive care was initiated.

In past reviews, it appeared that after members' health care needs are met, the member lost interest in case management and no longer returned calls or responded to letters requesting them to contact the case manager. This remains an issue. The case managers interviewed during the on-site reviews found this frustrating but continued their efforts to maintain a relationship with members while closing their case. When contact through closing and development of a transition plan occurred, case managers reported that members often contacted them afterward to seek assistance with short term problems.

1.6 Managed Care Heath Plan Report Card

Table 2 - 2016 Managed Care Report Card.

MCHP	PIPs	PM Validation	Compliance	Case Management	Score	Grade
Aetna Better Health	100%	66.7%	89.9%	77.3%	83.5%	**B**
Home State Health	90.7%	33.3%	92.8%	90.95%	76.9%	**C**
Missouri Care	81.4%	33.3%	89.9%	82.0%	71.7%	**C-**

The MCHPs were given scores in each of the validated areas; and these scores were averaged to award each MCHP with an Overall Score and Grade.

The scores for each validation area were calculated as follows:

Performance Improvement Projects – This score is an average of the ratings awarded by the EQRO for each of the two PIPs validated.

*For the scores awarded on each PIP, see Table 3 in Section 2.0 of this report.

Performance Measures – This score is an average of the following: Average of ratings received for Final Validation of each Performance Measure.

*For the scores awarded on each PM, please see Table 5 in Section 3.0 of this report.

Note: Each Fully Compliant rating received 2 points; each Substantially Compliant rating received 1 point; and each Not Valid rating received 0 points.

Compliance – This score is an average of the ratings awarded by the EQRO for each of the Compliance standards.

*For the scores awarded on each standard, see the MCHP Individual sections of this report (Sections 6.0 – 8.0).

Case Management - This score is an average of the ratings awarded by the EQRO for each of the Case Management components.

*For the scores awarded on each component, see Section 5.0 of this report.

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2.0 VALIDATING PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

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A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes, and outcomes of care, designed, conducted and reported in a methodologically sound manner." The State Medicaid Agency (SMA: Department of Social Services, MO HealthNet Division) elected to examine projects that were underway during the preceding calendar year 2016. This included evaluating the Statewide Project entitled "Improving Oral Health."

2.1 Purpose and Objectives

The focus of the PIPs is to study the effectiveness of clinical or non-clinical interventions. These projects should improve processes associated with healthcare outcomes. They are to be carried out over multiple re-measurement periods to measure: 1) improvement; 2) the need for continued improvement; or 3) stability in improvement because of an intervention. Under the MCHPs' contracts with the State of Missouri, each MCHP is required to have two active PIPs; one of them is clinical in nature, and the other one is non-clinical.

The EQRO reviews each PIP to determine if it was designed, conducted, and reported in a methodologically sound manner. The EQRO incorporates document review, interviews, and observation techniques to fully evaluate the components of each PIP. Specific feedback and technical assistance were provided to Missouri Care and Home State Health by the EQRO during on-site visits.

2.2 Findings

The PIPs identified for validation at each MCHP are:

Aetna Better Health	Improving Childhood Immunizations Improving Oral Health
Home State Health	Improving Immunization Rates in Home State Health Members in the First 2 Years of Life Improving Oral Health
Missouri Care	Improving Childhood Immunization Status Improving Oral Health

CLINICAL PIPS

All three MCHPs developed PIPs to improve the number of children who receive childhood immunizations by age two, as defined in the HEDIS Combo 3 specifications. All three MCHPs presented well-developed study topics that provided information on the ability of immunizations to prevent early childhood illnesses, such as diphtheria, measles, meningitis, polio, tetanus and whooping cough. Additionally, the MCHPs provided evidence that immunizations are valuable to communities as they prevent outbreaks of serious and communicable diseases.

Barriers to success were presented for members, providers, and each MCHP. Interventions were developed to address these barriers. In the CY 2016 review, all three MCHPs used their HEDIS rates as an "indicator" of the success of their interventions. The EQRO contends that the HEDIS rate is the outcome measure, as it reflects the number of children who receive immunizations as prescribed in Combo 3. The MCHPs should measure each intervention individually and determine what approaches are producing desired changes.

The Childhood Immunization PIPs are new. None of them has been in place for more than two years. All three MHCPs experienced a decrease in their HEDIS rates for the HEDIS Year 2017 (HY 2017). However, Aetna Better Health's rate was presented in March 2017, was unaudited by their HEDIS auditor, and did not include any Hybrid results. These factors and the closing of the MCHP at the end of April 2017 impact the comparison of Aetna's efforts to prior years.

Missouri Care and Home State Health did not present information regarding the effectiveness of individual interventions. Missouri Care uses a "multi- interventional" approach and can only generalize about this approach's effects on their HEDIS rates. Home State Health also listed multiple interventions, none of which were individually measured. This is an area where the MCHPs' approaches to PIP evaluation require further development.

NON-CLINICAL PIPS

All three MCHPs presented non-clinical PIPs that targeted Improving Oral Health. These non-clinical PIPs are in response to the requirement of a Statewide PIP in this topic area. The study topic presentation for each individual MCHP PIP used the information from the Statewide PIP as the foundation of their topic argument. Each MCHP added information about how this topic is pertinent to their members between the ages of two and 20. These topic presentations have been updated annually.

Each MCHP presented interventions that were implemented in CY 2016. These PIPs failed to measure the effectiveness of individual interventions. Therefore, the MCHP is unable to assess which interventions are effective. The MCHPs' HY 2017 rates either declined or remained steady. Both Missouri Care and Home State Health have experienced the same outcomes for at least two years.

An example of a measurable intervention was presented by Aetna Better Health. In June 2016, Aetna Better Health began sending a report to Affinia Healthcare including a listing of members who were non-compliant in obtaining an annual dental visit for at least six (6) months. The first report contained 2,500 non-compliant members. Affinia Healthcare contacted and made appointments with 500 of those patients (Aetna Better Health members). This non-compliant report was submitted to Affinia Healthcare monthly for the remainder of 2016. This intervention was designed to produce measurable results enabling Aetna Better Health to evaluate its effectiveness. Using this type of methodology would allow the MCHPs to discontinue interventions that are not producing the desired results. The inability of the MCHPs to reach their stated goal of a three (3) percent increase each year indicates that innovative approaches are needed.

The findings for each section of the evaluation of the PIPs, as required by the PIP Protocol: Validating Performance Improvement Projects, are presented in Table 3.

Specific results of the PIPs for each MCHP are as follows:

CLINICAL PIP FINDINGS

Aetna Better Health

Aetna Better Health's clinical PIP was developed to improve the rate of childhood immunizations for members up to two years of age. Aetna Better Health created a PIP with plan-specific interventions that address a complete set of required vaccinations. The data analysis will track compliance rates for all 14 childhood vaccinations (Combo 10), which includes Combo 3 immunizations measured in the HEDIS Childhood Immunizations Status (CIS) measure. The goal of this PIP is to increase the compliance rate of each of the sub-measures within Combo 3 to 90% by the second year of the PIP.

Focusing Aetna Better Health resources on increasing the number of children receiving all necessary immunizations will improve their goal of increasing preventive services. The baseline year for this PIP is the calendar year (CY) 2015. Interventions were developed to begin in January 2016. Their interventions were designed to address the following barriers:

Member Barriers:

- Parents or caregivers do not support immunizations.
- Parents are unaware of the need to schedule immunizations for their children.
- Some parents are unable to get to a doctor's office or health department during routine hours.
- Some parents' lack knowledge of the need for vaccinations and the time to schedule immunizations.
- Fear of vaccinations causing Autism or Mercury Poisoning.

Provider Barriers:

- PCPs do not provide immunizations or have vaccinations available, causing the member to find another site and a second visit to obtain them.
- Provider offices do not remind patients of needed appointments or schedule children's next routine visit.

Aetna Better Health Barriers:

- Aetna Better Health is not informed if a member obtains immunizations through their local health department. Local health departments do not necessarily bill for immunizations; and therefore, these actions are not captured in HEDIS administrative data. Unreported health department activities are also unavailable for a medical record pull. Some health departments are not aware of the importance of the HEDIS reporting process.
- Aetna Better Health does not have access to the DHSS immunization registry as DHSS does not directly share registry data with them. Aetna Better Health has experienced a data flow problem from the State database to the MCHP database. During 2016, a quarterly submission of this information generated by MO HealthNet began, which may improve data sharing in the future.
- Aetna Better Health lacks a consistent process ensuring that files received are entered into their HEDIS system.
- Aetna Better Health reports that they have received inconsistent data regarding those children who received immunizations.

The interventions planned as the result of this barrier analysis include:

Member Interventions:

- Use the current missed appointment reminder and birthday card system to notify parents of the need for immunizations.
- Use text messaging for qualifying families and mailers to remind caregivers that immunizations are needed.
- Inform parents of available transportation.
- Provide children with a growth chart through provider offices and health fairs.
- Provide an Immunization Fact mailer to parents of newborns at each child's 1st birthday.

Provider Interventions:

- Target Head Start for possible intervention opportunities.
- Review provider care gaps and identify them in reports to providers. Encourage providers to use care gaps as a tool to identify patients in need of services, and then contact patients who need follow-up services.

Aetna Better Health Interventions:

- Identify non-compliant members in top ten counties in each region and make a targeted call to inform members of the need for immunizations.
- Utilize Aetna Better Health's Lead Data Analyst to develop a relationship with the DHSS contact person to obtain registry information quarterly.
- Collaborate with Missouri Health Plus (a network of community health centers with teams of caregivers who are dedicated to patients' holistic needs) to obtain more accurate and timely data regarding children receiving immunizations.

Aetna Better Health has established their baseline using the HEDIS (HY) 2016 rates. The Quality Improvement team continued to meet throughout CY 2016 to establish more material interventions and to assess all potential barriers. The full implementation of this PIP began in January 2016. However, this project is now discontinued due to the closure of Aetna Better Health in April 2017.

Home State Health

Home State Health's clinical PIP was implemented in July 2015. Home State Health recognizes that childhood vaccinations protect children from many serious and potentially life-threatening diseases at a time in their lives when they are most vulnerable to disease. The goal of this project is to ensure that members receive all appropriate immunizations by age two. Home State Health is implementing this PIP to attain a target rate of 90% for the number of two-year-old children who receive the required vaccinations by the completion of this project.

Home State Health identified the following barriers to obtaining project goals:

Member Barriers

- Parents lack knowledge about the importance of immunizations; and believe that immunizations do not protect children from serious illness.
- Parents believe that immunizations are not safe and effective at protecting children from disease.
- Parents lack of knowledge that immunizations are required for school and child care activities.

- Parents lack of knowledge about the importance of each child obtaining immunizations to protect the community.

Home State Health designed the following interventions to assist in ameliorating these barriers:

Member Interventions:

- Implement an Early Periodic Screening, Diagnostic, and Treatment (EPSDT) program with St. Louis Medical Supply.
- Utilize the "New Mom" program and Traditional EPSDT tangible incentives and texting programs aimed at educating parents in their preferred mode of communication; and incentivize healthy behaviors including childhood immunizations.

Provider Interventions:

- Begin a Provider Care Gap Closure incentive to nine participating FQHCs where health centers close all gaps in HEDIS measurable care for a $25 incentive per member.
- Educate providers at practitioner offices on accurate coding practices.
- Pay for Performance agreements with hospital systems including electronic HEDIS Combo 10 immunization data.

Home State Health Interventions:

- Begin a collaboration with the Missouri School Nurses Association for enhanced processes allowing parents to grant school nurses permission to communicate with Home State Health.
- Create refined data submission processes with Missouri Health Plus (a network of community health centers with teams of caregivers who are dedicated to patients' holistic needs), to increase the immunization data included from HEDIS Combo 3 to Combo 10.
- Develop an enhanced partnership with County Health Departments for year-round medical record retrieval.

Home State Health developed new programs implemented during CY 2016. These interventions did not produce the results expected, as Home State Health experienced a decline in both Combo 3 and Combo 10 rates from CY 2015 to 2016 (-0.24 percentage points for

Combo 3; -2.40 percentage points for Combo 10). The rates for both Combo 3 and Combo 10 did not achieve the outcomes of meeting or exceeding the established goals for this project. Home State Health currently plans to continue with the infrastructure changes started in the CY 2016. They will assess the direct interventions with members, including mailing educational and informational materials designed to increase their understanding of wellness behaviors. Home State Health will focus interventions on providers that intend to close care gaps; and will use outreach telephone calls to directly communicate with members.

Missouri Care

Missouri Care's clinical PIP focused on improving the number of children who receive the immunizations required in HEDIS Combo 3 by their second birthday. The initial PIP interventions were implemented in 2015 with CY 2014 considered the baseline year. Missouri Care's HEDIS rates have not improved. The HEDIS 2016 rate was 64.22%, while the HEDIS 2017 rate declined to 56.02%. This is also a decline from the baseline year because the HEDIS 2015 rate was 62.72%. Missouri Care continues to assert that their "multi-interventional approach," to ensure that their rates are sustained or improved through member and provider engagement is the most effective approach to change.

Missouri Care identified the following barriers to accomplishing their goal for this PIP:

Member Barriers

- Parents believe that:
  - Vaccinations are the cause of autism;
  - Children can build immunity naturally; and
  - Vaccines expose children to toxins.
- Parents prefer to spread out the doses instead of getting them all at once - thus a child receives their last after their second birthday.
- Fear of side effects.
- Parents find it difficult to take time off from work to keep child's vaccination appointment.
- Transportation issues.

Provider Barriers

- A lack of provider education on clinical guidelines adopted by Missouri Care.

Missouri Care Barriers

- An inability to contact members that is related to frequent moves, change of phone number, and other demographic issues.

Missouri Care chose a multi-faceted approach to ensure that members and providers were engaged in improving services to members. Interventions implemented, according to the PIP submission, during 2016 included:

Member Interventions:

- Provide incentives to members who complete their well-child visits. (A 2015 intervention – not enhanced or changed in 2016.)

Providers Interventions:

- Incentives to providers to encourage them to provide required Childhood Immunizations.

Plan Interventions:

- Provider Flat-file Transfer – scraping immunization data directly from providers' Electronic Medical Record (EMR) system into WellCare's database. (Used in four provider groups.) (It should be noted that this is a method of improving data collection to enhance HEDIS rates. It is not an intervention that impacts or improves member services.)

Missouri Care intends to continue the successful interventions in the upcoming year while developing new interventions to continually improve members' overall health and the CIS-Combo 3 rates. Missouri Care plans to continue to measure the impact of this PIP on an ongoing basis, which will be accomplished by tracking and trending for significant increases in indicator rates over time. A Plan-Do-Study-Act cycle of continuous process improvement is used to assess and improve interventions. Missouri Care included new interventions planned for the CY 2017.

NON- CLINICAL PIP FINDINGS

Each of the MCHPs had a non-clinical PIP that responded to the Statewide PIP initiative "Improving Oral Health."

Aetna Better Health

Aetna Better Health's PIP included and explanation of how the project individually addressed their population.

The following interventions were added to their project for the CY 2016:

- Building a relationship with one large FQHC, Affinia Healthcare, as a best practice model. Aetna Better Health independently and in collaboration with the Dental Health Task Force, began conversations with Affinia Healthcare in St. Louis, MO. This FQHC has a new dental facility with ninety-two (92) dental chairs, and is staffed by full-time workers and students from A.T. Still University's Missouri School of Dentistry and Oral Health.
- In June 2016, Aetna Better Health began sending a report to Affinia of their members who were non-compliant in obtaining an annual dental visit for at least six (6) months. The first report sent to Affinia contained 2,500 non-compliant members. Affinia made appointments with 500 of their patients (Aetna Better Health members) as the result of working on this report. Subsequent reports were submitted to Affinia monthly for the remainder of 2016.

Aetna Better Health's Annual Dental Visit HEDIS rate was changed from HY 2016 to HY 2017 as follows:

- Eastern Region – Decreased by .78%;
- Central Region – Increased by 1.20%;
- Western Region – Decreased by 1.20%; and
- Statewide Aggregate – Decreased by .58%.

At the end of the first quarter of 2016, Aetna Better Health recognized irregularities in provider reports between the MCHP and their dental subcontractor, DentaQuest. They learned that the Aetna Better Health software was not counting dental services provided by dentists listed as "general practitioners," and was counting member interactions with these providers as medical rather than dental visits. The problem was corrected in June 2016, and improvements were

identified beginning in August 2016. Aetna Better Health projected that, with the changes in the system and the improvements experienced in the Affinia Healthcare project, they would have shown improvement in the Eastern Region.

Aetna Better Health did not meet their goal of a 3% improvement in the HEDIS rate for the CY 2016. This is the second year that Aetna Better Health failed to meet their goal. Due to the stagnant growth toward goal attainment in the past two years, the Project Lead presented significant changes to Aetna Better Health's interventions for this project. However, due to the expiration of Aetna Better Health's contract with MO HealthNet, this PIP has been discontinued.

Home State Health

Home State Health presented information that included an explanation of how this project was pertinent to their members. The study topic presentation was thorough and focused on enhancing available and preventive dental care.

The interventions underway in 2016 were:

Member Interventions:

- Developing a partnership with Clarity Health Clinics to ensure that Home State Health members are targeted and treated in the Hannibal area – including Marion, Ralls, Monroe, Montgomery and Pike Counties. Home State Health also developed a fluoride varnish program, and initiated this project with Clarity school nurses.
- Partnering with Evolve Dental (Home State Health's dental subcontractor) to attend Affinia sponsored health fairs. Home State Health contacted members in advance of these health fairs to make appointments for dental services at the site.
- Evolve Dental mailed a letter and a toothbrush package to members who visited Emergency Departments for dental issues.
- Beginning in July 2016, existing eligible members received a Primary Care Dental (PCD) assignment; and ID cards were mailed.

Provider Intervention:

- Developing a provider incentive for Care Gap Closure with Missouri Health Plus, which included the ADV Measure.

The Home State Health ADV rate for HY 2016 was 40.90%. The goal was to improve the Home State Health's ADV rate "by 3 percentage points with the goal for HY 2017 of 43.90%." Home State Health did not meet this HY 2017 goal, as they achieved a rate of 39.91%. Home State Health provided the following assessment of the reasons for their declining rates from HY 2015 (42.78%) to HY 2017 (39.91%):

- "Many of the interventions are forward looking and structural in nature. The partnerships with the Missouri Health Plus, St. Louis Medical Supply, and Evolve Dental are designed to engage both members and providers to increase awareness and access to care.
- The precipitous increase in membership, somewhat due to auto-enrollment, increases members who are not acclimated nor familiar with the managed care processes and do not have an established relationship with Home State Health nor a provider."

Home State Health asserts that they experienced a 32% increase in membership in 2015 and again 2016, which impacted their HEDIS outcomes. However, this argument appears to have minimal impact on the rates. The eligible population is children who reach their 2nd birthday during the measurement year, and who are continuously enrolled for 12 months prior to the child's second birthday. These factors would eliminate most new members from the population included in each year's HEDIS population.

Home State Health identified process problems with their interventions. They provided the following explanation of why the interventions employed in both HY 2016 and HY 2017 did not yield the increases they anticipated:

- "The initiative with St. Louis Medical Supply provided the member with a toothbrush, floss and toothpaste, along with a card informing the parent of how to locate a dental provider." This is informative, but did not actually create a visit to the dentist. Home State Health plans to continue this intervention through HY 2018. Their explanation did not provide details about changes that might produce the required dental visit.
- "The utilization of dental vans did not yield an increase in the ADV rate, although this intervention is designed to add convenience to an actual visit. The van providers refused to comply with billing standards that would allow these services to become numerator compliant." Home State Health's planning included work with selected vendors to identify partners who can deliver on a larger and more meaningful scale.

- "Affinia Healthcare, a large FQHC with ninety-two (92) dental chairs, had administrative and provider challenges, which restricted forecasted volumes of treatments." Home State Health planned to continue to partner with Missouri Health Plus to work with all FQHCs including Affinia Healthcare. The FQHCs have the potential to offer dental services, generating positive ADV rates in the Eastern Missouri MO HealthNet Region.

Home State Health witnessed a decrease in their overall ADV rates during the past two (2) years. The MCHP has committed to several long-term projects designed to empower providers with the ability to identify non-compliant members and to conduct assessments, treatments and the referral of members with oral health problems. The MCHP has also promoted long-term plans for members to develop a Dental Home, receive fluoride varnish, and have more choices for dental access. The MCHP states that, with the involvement of their Quality Improvement Team's efforts, as well as their collaboration with Missouri Health Plus provider incentives, they will reach their goals.

Missouri Care

Missouri Care's individualized approach to the Statewide PIP Improving Oral Health has the goal to: "Improve members' oral health outcomes through education and on-going interventions." Missouri Care's research found that dental care is the most prevalent unmet health need among children in the United States. Access to dental services is an ongoing challenge for their members. To achieve this goal, new interventions were implemented during CY 2016 including:

Member Interventions:

- Maintaining a successful collaboration with DentaQuest to utilize the Smiling Stork program, for educational purposes.

Provider Interventions:

- Housing Authority Partnership – Partnering with local Housing Authorities to host Back to School and Health Fairs that will focus on providing dental screenings and education for participants.
- Partnership with Affinia Healthcare – Missouri Care Community Outreach will collaborate, through their Dental Home Project, with Affinia Healthcare in the Eastern Region.

- Continued development of the dental home pilot project – Missouri Care designates a dental primary care provider and encourages the routine use of dental services.

Missouri Care supplied HEDIS rates for each region as well as statewide. Missouri Care achieved the goal of a 3% improvement for CY 2014. The rates and data presented for that year indicate a statistically significant improvement over the previous year. The current HEDIS rates are the highest achieved by Missouri Care. The statewide rates for the MCHP are:

- CY 2012 – 43.91%
- CY 2013 – 31.39%
- CY 2014 – 45.74%
- CY 2015 – 46.60%
- CY 2016 – 46.97%

Missouri Care concluded that the interventions in place are producing positive outcomes, so that they will continue. Missouri Care's rate is increasing. However, the improvement is only 1.23 percentage points in the last two years. This does not meet the goal of 3% per year, and leaves questions about the effectiveness of their interventions. The MCHP achieved a 6.96% increase from the CY 2012 (baseline year) to the CY 2016. This does not meet their overall goal of a 12% improvement for this same period.

Missouri Care provided a narrative that details the outcomes achieved in all three regions, and statewide. They asserted that the initiatives in place were directly responsible for the improvement achieved, even though they did not reach the 3% increase sought in CY 2016. The MCHP stated that they will continue to monitor the effectiveness of current interventions, as well as assess the outcomes of new interventions. New interventions for CY 2017 were presented. The narrative states, "An opportunity was identified for Case Managers to educate members that are actively engaged, on their annual dental benefits, as well as prevention." This opportunity is integrated in the CY 2017 interventions.

Table 3 - Performance Improvement Validation Findings by MCHP.

Steps		Aetna Better Health			Home State Health			Missouri Care	
		Improving Childhood Immunizations	Improving Oral Health		Improving Immunization Rates in Home State Health	Improving Oral Health		Improving Childhood Immunization Status	Improving Oral Health
1: Selected Study Topics	1.1	2	2		2	2		1	2
	1.2	2	2		2	2		1	2
	1.3	2	2		2	2		2	2
2: Study Question	2.1	2	2		2	2		1	2
3: Study Indicators	3.1	2	2		2	2		2	2
	3.2	2	2		2	2		2	2
4: Study Population	4.1	2	2		2	2		2	2
	4.2	2	2		2	2		2	2
5: Sampling Methods	5.1	NA	NA		NA	NA		NA	NA
	5.2	NA	NA		NA	NA		NA	NA
	5.3	NA	NA		NA	NA		NA	NA
6: Data Collection Procedures	6.1	2	2		2	2		2	2
	6.2	2	2		2	2		2	2
	6.3	2	2		2	2		2	2
	6.4	2	2		2	2		2	2
	6.5	2	2		2	2		2	2
	6.6	2	2		2	2		2	2
7: Improvement Strategies	7.1	2	2		2	2		1	2
8: Analysis and Interpretation of Study Results	8.1	2	2		2	2		2	2
	8.2	2	2		2	2		2	2
	8.3	2	2		1	2		1	1
	8.4	NA	2		1	2		1	2
9: Validity of Improvement	9.1	2	2		2	2		2	2
	9.2	NA	2		1	2		1	2
	9.3	NA	2		1	NA		NA	2
	9.4	NA	2		NA	NA		NA	NA
10: Sustained Improvement	10..1	NA	2		NA	NA		NA	NA
Number Met		19	24		18	21		14	21
Number Partially Met		0	0		4	0		7	1
Number Not Met		0	0		0	0		0	0
Number Applicable		19	24		22	21		21	22
Percent Met		100%	100%		81.82%	100%		66.67%	95.45%

Source: BHC, Inc., 2016 External Quality Review Performance Improvement Project Validation.
Met = 2; Partially Met = 1; Not Met = 0.

VALIDATION STEPS

Each PIP is validated based on ten steps that are identified in Table 3. In the 2016 review, eight elements were not completely met. The sections considered "Partially Met" include:

Home State Health – Clinical PIP

- Step 8.3: Home State Health asserts that their membership increase of 32% in 2015 and again in 2016 impacted the HEDIS outcomes. However, this argument appears to have minimal impact on the HEDIS rates. The eligible population for the Childhood Immunization Status HEDIS measure includes children who reach their second birthday during the measurement year, and who were continuously enrolled for twelve (12) months prior to their second birthday. These factors eliminate most new members from being included in each year's HEDIS population.
- Step 8.4: Home State Health stated that the number of provider and member incentives, related to texting and electronic data exchanges and various care gap closure processes will address any identified barriers. Home State Health does not have evidence that supports that these interventions will produce the improvement anticipated. Individual interventions have not been measured to enable Home State Health to learn what is or is not truly effective.
- Step 9.2: Home State Health recognized that the interventions utilized have not produced the desired results. They did not provide any hypothesis about why this occurred.
- Step 9.3: There was a decline in the HY 2017 rates in one MO HealthNet Region, and a slight increase in the rate in two regions. The aggregate rate also decreased. The impact of the interventions was negligible, so it was not possible to assess if the interventions had "face" validity.

Missouri Care – Clinical PIP

- Step 1.1: The narrative provided by Missouri Care included how they related their current performance to the decision to implement a PIP focused on improving the number of children receiving needed immunizations. The presentation does not provide a link between the decision to develop this PIP and issues within the Missouri Care population.

- Step 1.2: Missouri Care designed this PIP to improve the number of children receiving immunizations and stated that this is an important aspect of preventive care. An explanation of why this is important to Missouri Care members, other than improving their HEDIS rates, is not included.
- Step 2.1: The narrative explaining the study question included the fact that Missouri Care will implement member education interventions, and interventions to increase the percentage of members receiving the stated immunizations. Missouri Care wants to improve their HEDIS rates for Combo 3 and Combo 10. The current percentage of children/members receiving immunizations within Missouri Care is not provided. The narrative does not: include details about Missouri Care's goal to increase their HEDIS rate to 90%; explain if this is a long term or short-term goal; or state how far they are from achieving this goal. The interventions did not address member education, as stated in the study question.
- Step 7.1: In 2016, Missouri Care initiated one revised intervention for providers. The only member-focused intervention started in 2015. Other member interventions were ongoing or began in 2014. Missouri Care must specify revised or enhanced interventions for each study year. The method for including interventions is somewhat confusing in the narrative provided. For example, a 2014 "Member Engagement" intervention is stated as "using MOHSAIC data quarterly." However, this is a strategy to utilize an information source. It is not a method or intervention to engage members in obtaining immunizations.
- Step 8.3: Factors that influenced the outcomes achieved were not identified. The HEDIS 2017 rate declined to 56.02% from a rate of 64.22% (HEDIS 2016). The factors that influenced these outcomes were not discussed.
- Step 8.4: There was some limited analysis of the outcomes provided in the narrative. However, the presentation lacked discussion or interpretation of how the interventions contributed to the outcomes achieved. Providing this analysis could give insight into changes needed to create positive outcomes.
- Step 9.2: There is no improvement in the aggregate outcomes for HY 2017. The narrative calls out some improvement by region. However, there is very little analysis of why differences occurred.

Missouri Care – Non-Clinical PIP

- Step 8.3: A thorough analysis of what factors influenced change or why was not presented. The same barriers have been included for the last two (2) years. In CY 2016, one additional member barrier, and one additional provider barrier were included. None of the previous barriers were eliminated. Some of these barriers should be resolved if the PIP is having a positive effect. In previous PIP submissions, a list of system (Missouri Care) barriers was included, but none were included in the CY 2016 PIP. The EQRO is left to wonder if these have been resolved. If so, an explanation of this success should be included.

For further information and specifics, including the completed PIP Validation Tool for each MCHP and their response to these steps, see their individual sections.

2.3 Conclusions

Based on the PIP validation process, all the MCHPs had active and ongoing PIPs as part of their quality improvement programs. A need to revitalize a commitment to the quality improvement process was observed when evaluating the outcomes of the PIPs. The three clinical PIPs were new and did not have complete results to report. The three non-clinical PIPs were rated as producing "Moderate Confidence" that the PIP was directly responsible for the reported outcomes. The PIPs exhibited sound planning; but the analysis and reporting need improvement. Even though the PIPs are not completed and some sections were coded as "Partially Met," the information presented was informative and most included adequate information to complete the required EQRO analysis. The PIPs did not provide enough information to relate the interventions to the outcomes reported. Additional work is needed to create measurements for each intervention to assess whether that intervention is successful.

All the PIPs submitted that contained reportable outcomes included some narrative in the data analysis. How the interventions contributed to success, or analysis of why interventions did not create the desired changes, was not included. This type of evaluation is as important as the data analysis presented.

Table 4 - Validity and Reliability of Performance Improvement Project Results.

PIP Name	Rating
Improving Childhood Immunizations (Aetna Better Health)	Unable to Determine
Improving Oral Health (Aetna Better Health)	Moderate Confidence
Improving Immunization Rates in HSH Members in the First 2 Years of Life (Home State Health)	Unable to Determine
Improving Oral Health (Home State Health)	Moderate Confidence
Improving Childhood Immunization Status (Missouri Care)	Unable to determine
Improving Oral Health (Missouri Care)	Moderate Confidence

Source: BHC, Inc., 2016 External Quality Review Performance Improvement Project Validation. Note: Moderate Confidence = Many aspects of the PIP were described or performed in a manner that would produce some confidence that findings could be attributed to the intervention(s); Unable to Determine: The PIP is new and has not yet produced results.

The interventions developed for the PIPS are not adequate. In four PIPs, little or no improvement occurred. The MCHPs continue to use and reuse interventions that have failed to create the change hoped for in these projects. Innovative approaches to positively impact the problems identified are necessary. As interventions are implemented, a method to measure each interventions' outcome must also be introduced. Three PIPs exhibited declining rates in the HEDIS measures that were used as the outcome indicator. One PIP showed improvement, but it was minimal (1.23 percentage point over the past two years).

Quality of Care

The topics identified by all MCHPs for their PIPs provide evidence of their commitment to providing quality services to members. However, the interventions for these PIPs were less thorough and well-developed than seen in previous years. The PIPs did focus on improving direct services to members. Some PIP interventions were designed to address barriers to quality care. These included partnering with Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs). These initiatives targeted members who were not utilizing their childhood immunization or annual dental visit benefits.

All the PIPs reviewed included the stated goal of providing quality healthcare services. However, some PIPS did not identify how effective current interventions were in the 2016 review. This is an area to be addressed in future PIPs. The MCHPs must focus on new and creative initiatives that help them meet this goal.

Access To Care

The MCHPs developed projects that targeted members' ability to obtain dental care and childhood immunizations by expanding service availability. These projects have the potential to create improved preventive and primary care for members. At the time of this review, all the clinical PIPs were too new to assess their success. Conversely, the non-clinical PIPs regarding improved annual dental visits exhibited minimal measurable success. The non-clinical PIPs, submitted by all three MCHPs have not reached the goal of improving by 3% each year. However, during the EQRO's on-site discussions with MCHP staff, they indicated that improving access to care is an underlying goal of all the projects they develop.

Timeliness of Care

Timeliness of care was also addressed in the PIPs reviewed. Projects addressed timely access to dental care and childhood immunizations, and concentrated on the need for timely and appropriate care for members. The Improved Oral Health PIPs included interventions to improve timeliness of care. Examples of these interventions include: engaging a new FQHC to partner in providing dental services; developing "dental homes" so that members are aware of their provider; and activities to ensure access to services when they are needed. These interventions and discussions with MCHP staff reflect an awareness of the importance of timely healthcare.

Recommendations

1. MCHPs must continue to refine their skills in the development and implementation of approaches to effect change in their Performance Improvement Projects. Improved training, assistance and expertise for the design, statistical analysis, and interpretation of PIP findings are available from the EQRO, CMS publications, and research review.
2. PIPs should be conducted on an ongoing basis, with at least quarterly measurement of some indices to provide data about the need for changes in implementation, data collection, or interventions. The PIPs presented include quarterly review in the study design. However, the results of these interim reviews and any changes made to alter interventions are not included in the information provided. The decisions regarding any changes made as the result of quarterly reviews should be documented, and should include the measurements that indicated a need for these changes.

3. Data analysis is not just the presentation of graphs and tables. What the data tells us and how it is interpreted by the MCHP are essential in the development of an effective project. The narrative must also include an interpretation of how the interventions contributed to success or the lack of success during the project year.
4. Document how external factors threaten internal or external validity; and what was learned from statistical significance testing.
5. Efforts to improve outcomes related to the Statewide PIP topic should be continued. The MCHPs must evaluate the success or lack of success of current interventions, maintain those that are successful, and develop and implement new strategies each year.
6. MCHPs must utilize the PIP process as part of organizational development to maintain compliance with the State contract and the federal protocol.

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3.0 VALIDATION OF PERFORMANCE MEASURES

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3.1 Purpose and Objectives

The EQRO is required by the Validating Performance Measures Protocol to evaluate three performance measures reported by each MCHP. These measures are selected by MO HealthNet each year. For the 2016 evaluation period, the three performance measures selected for validation included:

1. HEDIS 2016 measure Prenatal and Postpartum Care (PPC);
2. Emergency Department Visits (EDV); and
3. Emergency Department Utilization (EDU).

Protocol activities performed by the EQRO for this audit included:

1. Review of the processes used by the MCHPs to analyze data;
2. Evaluation of algorithmic compliance with performance measure specifications; and
3. Recalculation of either the entire set of performance measure data (administrative rates) or a subset of the data (hybrid rates) to verify and confirm the rates reported by the MCHPs are based upon accurate calculations.

The objectives for validating performance measures were to:

1. Evaluate the accuracy of Medicaid performance measures reported by, or on behalf of the MCHPs; and
2. Determine the extent to which MCHP-specific performance measures calculated by the MCHPs (or by entities acting on behalf of the MCHPs) followed specifications established by MO HealthNet and the State Public Health Agency (SPHA; Missouri Department of Health and Senior Services; DHSS) for the calculation of the performance measure(s).

3.2 Findings

All MCHPs used the administrative method (use of claims/encounter data) to calculate the EDV and the EDU measures. The hybrid method (use of administrative data and medical record review) was used by all MCHPs to calculate the PPC measure.

The validation of each of the performance measures is discussed in the following sections with the findings from each validation activity described. Subsequent sections summarize the

submission of the measures to MO HealthNet and SPHA, the Final Audit Ratings, and conclusions.

The EQRO is required by the CMS Protocol to assess each performance measure in the areas of:

- Data Integration and Control
- Documentation of Data and Processes
- Processes Used to Produce Denominators
- Processes Used to Produce Numerators
- Sampling Procedures (for Hybrid Method)
- Submission of Measures to the State

The EQRO assesses these areas based on the methodology and technical methods described in their Supplemental Report of Technical Methods, which is available on the MO HealthNet website.

All MCHPs met all criteria for every audit element in data integration and control, sampling procedures, and submission of measures to the State. The Documentation of Data and Processes, the Processes Used to Produce Denominators, and the Processes Used to Produce Numerators were problematic for both Home State Health and Missouri Care. The specific issues with these elements are included in the discussion as follows.

Overall Validation Findings

The rate of compliance with the calculation of each of the three performance measures across all MCHPs was 73.81% for Emergency Department Visits; 100% for Prenatal and Post-Partum Care; and 73.81% for Emergency Department Utilization.

Table 5 summarizes the final audit ratings for each of the performance measures by MCHP. The final audit findings for each of the measures was based on the evaluation of processes for calculating and reporting the measures, medical record review validation findings, and MCHP extract files from repositories. The ratings were based on the impact of medical record review findings and the degree of overestimation of the rate as validated by the EQRO. The calculation

of measures was considered invalid if the specifications were not properly followed, if the rate could not be properly validated by the EQRO due to missing or improper data, or if the rate validated by the EQRO fell outside the confidence intervals for the measure reported by the MCHPs on the HEDIS Data Submission Tool (DST).

The original responses received by Missouri Care and Home State contained inaccuracies and omitted data for both the Emergency Department Visits and Emergency Department Utilization measures. Missouri Care's submission did not contain each members' date of birth in the same file as the service date and contained "inpatient admit dates" for all members. Since the technical specifications for these measures require that only observation stays not resulting in an inpatient stay be counted, these files cannot be validated. Additionally, Home State Health's submission did not delineate the region where each member belonged. Therefore, the EQRO was unable to recalculate any of the Home State Health's submitted data by region. Due to the inaccuracies of the data received, both Missouri Care and Home State Health were asked to resubmit data for both the EDV and EDU measures. These resubmissions were received by the EQRO on November 6, 2017. The analysis in this section is representative of the data received on November 6, 2017.

Table 5 - Summary of EQRO Final Audit Ratings: HEDIS 2016 Performance Measures.

MCHP	Prenatal and Postpartum Care (PPC)	Emergency Department Visits (EDV)	Emergency Department Utilization (EDU)
Aetna Better Health	Fully Compliant	Substantially Compliant	Substantially Compliant
Home State Health	Fully Compliant	Not Valid	Not Valid
Missouri Care	Fully Compliant	Not Valid	Not Valid

Source: BHC, Inc. 2016 EQR Performance Measure Validation Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCHP. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No Managed Care Members qualified for the measure.

HEDIS 2016, Prenatal and Postpartum Care Measure(PPC)

The PPC measure is defined as an Access/Availability of Care measure by HEDIS. It contains two measures:

- Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the MCHP in the first trimester or within 42 days of enrollment in the MCHP.
- Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MCHPs' ability to accurately identify medical events, evaluate the MCHPs' ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review the time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. For the HEDIS 2016 PPC measure, the sources of data included enrollment, eligibility, claim files, and medical records. The denominator for each MCHP is the Final Sample Size as approved by HEDIS Technical Specifications. The rate for all MCHPs for Prenatal Care was 78.17% and the rate for all MCHPs for Postpartum Care was 62.73%.

Tables 6 and 7 illustrate the rates reported by the MCHPs and the rates of administrative and hybrid hits for each MCHP. The rate reported by each MCHP was compared with the rate for all MCHPs.

Table 6 - Data Submission for HEDIS 2016 Prenatal Measure.

MO HealthNet MCHP	Final Data Collection Method Used	Denominator (DST)	Administrative Hits Reported by MCHP (DST)	Hybrid Hits Reported by MCHP (DST)	Total Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)
Aetna Better Health	Hybrid	429	248	105	353	82.28%
Home State Health	Hybrid	422	225	90	315	74.64%
Missouri Care	Hybrid	418	216	108	324	77.51%
All MO HealthNet MCHPs		**1,269**	**689**	**303**	**992**	**78.17%**

Source: MCHPs' HEDIS 2016 Data Submission Tools (DST).

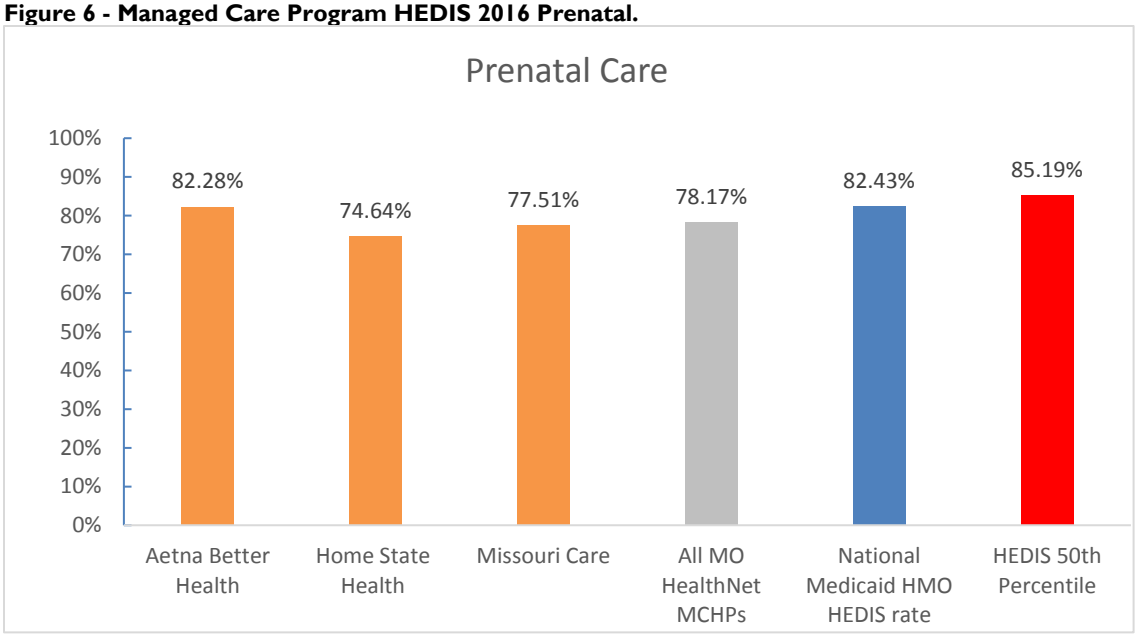
Table 7 - Data Submission for HEDIS 2016 Postpartum Measure.

MO HealthNet MCHP	Final Data Collection Method Used	Denominator (DST)	Administrative Hits Reported by MCHP (DST)	Hybrid Hits Reported by MCHP (DST)	Total Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)
Aetna Better Health	Hybrid	429	223	55	278	64.80%
Home State Health	Hybrid	422	171	89	260	61.61%
Missouri Care	Hybrid	418	184	74	258	61.72%
All MO HealthNet MCHPs		**1,269**	**578**	**218**	**796**	**62.73%**

Source: MCHPs' HEDIS 2016 Data Submission Tools (DST).

Due to the audit of other measures, the PPC measure has not been audited since 2006; therefore, trend analysis was not examined for this 2016 review year. However, the Prenatal Care rate for all MCHPs (78.17%) was lower than both the National Medicaid rate of 82.43% and the HEDIS 50th Percentile (85.19%) (See Figure 6).

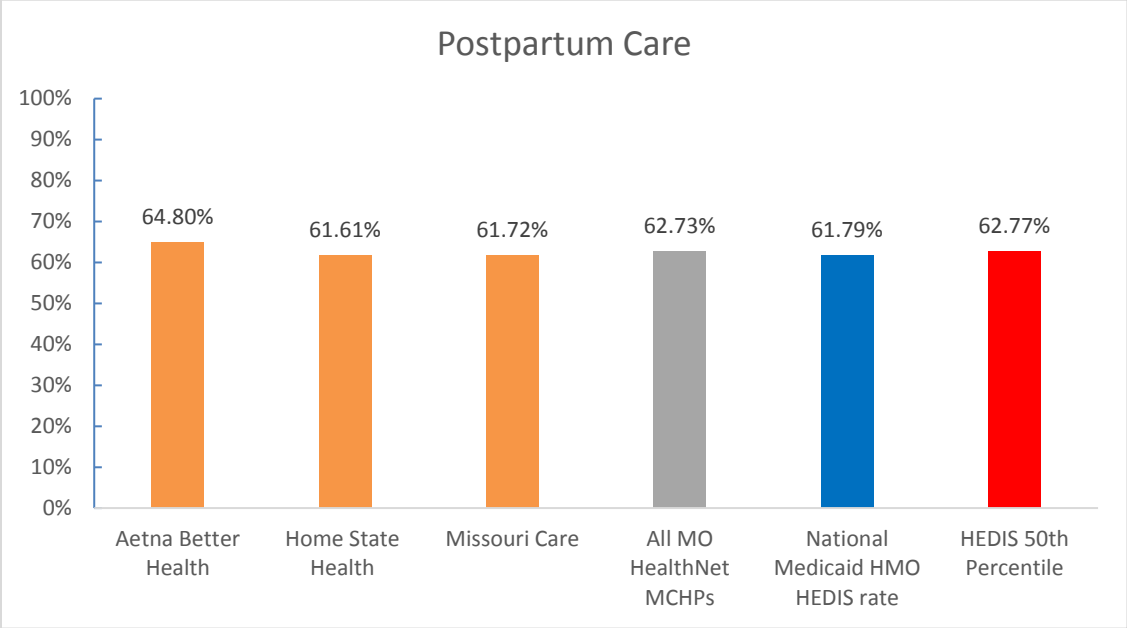
Figure 6 - Managed Care Program HEDIS 2016 Prenatal.



Sources: MCHP HEDIS 2016 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

The Postpartum Care rate for all MCHPs was higher than the National Medicaid rate of 61.79% and consistent with the HEDIS 50th Percentile (62.77%) (See Figure 7).

Figure 7 - Managed Care Program HEDIS Postpartum Care.



Sources: MCHP HEDIS 2016 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Each MCHP calculated the Prenatal and Postpartum measure using the hybrid method for calculation. There were no statistically significant differences between the rates reported and the average for all MCHPs. All MCHPs operate in multiple regions. For this review all MCHPs supplied the EQRO with an audited statewide rate.

The EQRO requested and received 37 medical records for review. The EQRO validated all 37 of the records received, resulting in an Error Rate of 0% for Home State Health and Missouri Care. This shows no bias in the estimation of hybrid rates for the MCHPs based upon medical record review. A medical record sample was not requested from Aetna Better Health due to the expiration of their contract with the MO HealthNet. All three MCHPs met all validation requirements for the process used to produce numerators.

Sampling Procedures for Hybrid Method

The objective of this activity was to evaluate the MCHPs' ability to randomly sample from the eligible members for the measure when using the Hybrid Method of calculation. Across all MCHPs, the criteria for sampling were met 100% of the time. All MCHPs used the Hybrid Method of calculating the HEDIS 2016 Prenatal and Postpartum measure and all met 100.0% of the criteria for proper sampling.

2016 Emergency Department Visits

The EDV measure is an Access to Care measure. The EDV measure reflects the count of emergency department visits that occurred during the measurement year. These visits are then stratified by age and presenting diagnosis (Behavioral Health; Medical; or Substance Abuse).

MO HealthNet requested that the EQRO validate the number of Emergency Department Visits that were reported by each MCHP to MO HealthNet in the Healthcare Quality Data Template. This report was due on June 30, 2016, and contained 2015 data.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MCHPs' ability to accurately identify medical events, evaluate the MCHP's ability to identify events from other sources; evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, assess the processes and procedures for collecting and incorporating medical record review data, and to reproduce the data used to complete the June 30, 2016 Healthcare Data Quality Template report. This is the second year that MO HealthNet has asked the EQRO to validate the information contained in the Healthcare Data Quality Template report. Tables 8 and 9 show the number of EDVs reported with a primary medical diagnosis in the June 30, 2015 and July 30, 2016 Healthcare Quality Data Template reports. These tables also detail the number of EDVs validated by the EQRO based on the data supplied to the EQRO by the MCHPs.

Emergency Department Visits for Medical diagnoses

The calculation of the EDV-Medical measure is based upon the Ambulatory Care (AMB) measure from the HEDIS 2016 Technical Specifications. The AMB specifications require a count of every visit to an Emergency Department that does not result in an inpatient stay, regardless of the duration or intensity of the visit. The measure was calculated with one modification, which included sorting the results into age groupings as specified by MO HealthNet. The EDV-Medical measure does not include emergency department visits for any mental health or chemical dependency diagnoses or services.

Table 8 - Data Submission and Final Validation for 2015 EDV Medical report (combined rate).

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	241146	207717	86.14%	111122	46%	40.06%
Home State Health	74890	59291	79.17%	111480	149%	-69.69%
Missouri Care	102918	79585	77.33%	79560	77%	0.02%
Total	418954	346593	82.73%	302162	72%	10.61%

Note: NA = Not Applicable; Eligible Population = number of members reported by MCHP to MO HealthNet; Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP - Rate Validated by EQRO. Positive bias indicates an overestimate. **Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year2014.**

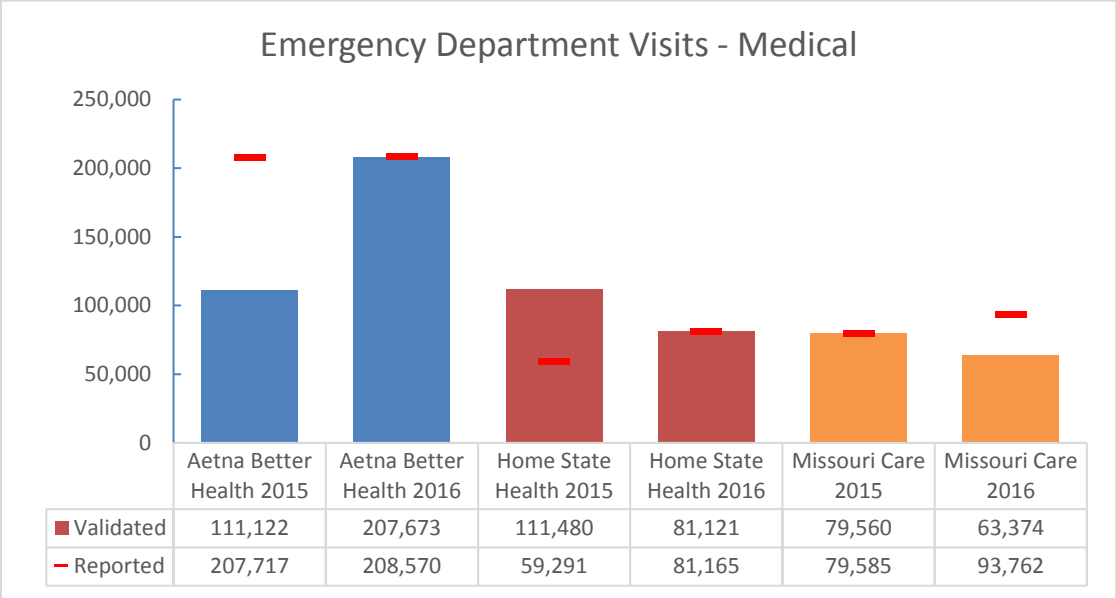
Table 9 - Data Submission and Final Validation for 2016 EDV Medical report (combined rate).

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	243691	208570	85.59%	207673	85.22%	0.37%
Home State Health	96949	81165	83.72%	81121	83.67%	0.05%
Missouri Care	114706	93762	81.74%	63374	55.25%	26.49%
Total	455346	383497	84.22%	352168	77.34%	6.88%

Note: NA = Not Applicable; Eligible Population = number of members reported by MCHP to MO HealthNet; Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP - Rate Validated by EQRO. Positive bias indicates an overestimate. **Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2015.**

Both Aetna Better Health and Home State Health responded to the EQRO's data request with data that could be recalculated to produce a rate for the combined EDV Medical measure. Those recalculated rates were comparable to the numbers reported to MO HealthNet.

Figure 8 – Statewide Comparison for EDV – Medical measure.



Source: BHC, Inc., 2015 and 2016 External Quality Review Performance Measure Validation.

For the 2016 review, Aetna Better Health reported to MO HealthNet a total number of EDV-Medical visits of 208,570, and the EQRO validated 207,673 hits. The difference of 897 records shows an overestimate of 0.37%. This is an improvement over the 2015 validation of this measure for Aetna Better Health. In 2015, Aetna Better Health reported 207,717 EDV-Medical visits; however, the data provided to the EQRO only contained a total of 115,823 records to be analyzed. Therefore, making it impossible for the EQRO to find and validate a total of 207,717 EDV-Medical hits. The difference of 96,595 hits was an overestimate of 40.06%. At the time of the last report, the EQRO attributed this difference to missing records or an incorrect number of hits reported to MO HealthNet on the 2015 Healthcare Quality Data Template report. Based on the level of accuracy of the 2016 submission, the EQRO attributes the inaccuracy of the 2015 submissions to a reporting error on the part of the MCHP.

For the 2016 review, Home State Health supplied an enrollment file that contained 328,359 lines of data; from those lines of data, the EQRO identified 119,602 unique members. The data supplied by Home State Health to MO HealthNet listed a total eligible population of 114,706. Home State Health supplied a numerator file to the EQRO that contained a total of 81,121 EDV-Medical hits. However, Home State Health reported 81,165 hits to MO HealthNet for the EDV-Medical measure. This is a slight underestimate of 0.05%. In the 2015 review, the EQRO found a difference of 52,189 hits between the MCHP's reported numbers and the EQRO validated numbers, this was an underestimate of 69.69%. This overestimate was attributed to an

incorrect calculation in the data submitted to MO HealthNet or an incorrect data submission to the EQRO. Although the numbers are much improved, Home State Health is still having difficulty providing the data as requested to both the EQRO and MO HealthNet. The MCHP contracted with their HEDIS vendor to calculate the numbers for the 2017 Healthcare Quality Data Template report; and hopefully this will ensure a more accurate submission.

For the 2016 review, Missouri Care provided an enrollment file for each of the MCHP regions. The total number of records contained in the three EDV enrollment files was 55,197, although the MCHP reported 114,706 eligible members to MO HealthNet. Missouri Care provided three numerator files (one for each MCHP region), the total number of records contained in these files was 95,802. The EQRO could validate 63,374 EDV-Medical hits from these files; therefore, the MCHP's 93,762 reported hits are an overestimate of 26.49%. There were 1,408 Missouri Care submitted records that contained an "Inpatient Admission Date" and 30,358 records that did not contain a service code or procedure code to validate that the service was an approved ER service. However, for the 2015 review, the EQRO found a difference of only 25 records, an overestimate of only 0.02%. The amount of incorrect data submitted by Missouri Care for the 2016 review calls in to question the accuracy of the data originally submitted in the Healthcare Quality Data Template.

Emergency Department Visits for Behavioral Health Diagnoses

The calculation of the EDV-Behavioral Health measure is based on the Mental Health Utilization (MPT) measure from the HEDIS 2016 Technical Specifications. The MPT measure is designed to count all visits made by members who received mental health services in an Emergency Department (ED) setting. The MPT specifications were modified to separate Outpatient and ED visits and to only include observation stays that do not result in an inpatient stay. All visits for this measure are required to have a valid mental health diagnosis. Additionally, the place of service (POS) for all ED services was limited to the acceptance of only the POS=23 code, which indicates the service occurred in the ED.

Table 10 - Data Submission & Final Validation - 2015 EDV Behavioral Health report (combined rate).

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate calculated from hits reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	216151	2625	1.21%	3408	1.58%	-0.36%
Home State Health	71476	1128	1.58%	693	0.97%	0.61%
Missouri Care	97996	1216	1.24%	1207	1.23%	0.01%
Total	385623	4969	1.29%	5308	1.38%	-0.09%

Note: NA = Not Applicable; Eligible Population = number of members reported by MCHP to MO HealthNet; Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP - Rate Validated by EQRO. Positive bias indicates an overestimate. **Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2014**

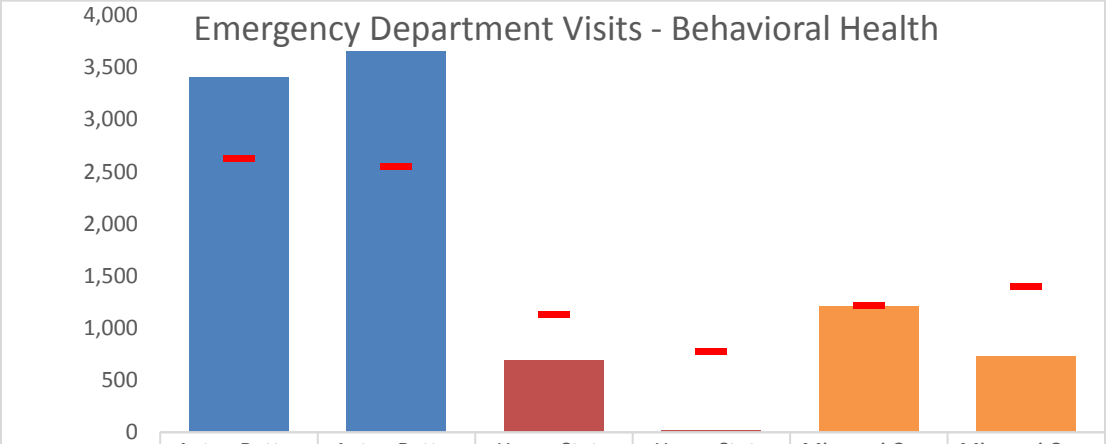
Table 11 - Data Submission & Final Validation - 2016 EDV Behavioral Health report (combined rate)

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	243691	2,552	1.05%	3655	1.50%	-0.45%
Home State Health	96949	771	0.80%	17	0.02%	0.78%
Missouri Care	114706	1394	1.22%	383	0.33%	0.89%
Total	455346	4717	1.04%	4,055	0.93%	0.11%

Note: NA = Not Applicable; Eligible Population = number of members reported by MCHP to MO HealthNet; Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP - Rate Validated by EQRO. Positive bias indicates an overestimate. **Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2015**

The numbers reported in the Healthcare Data Quality Template by Aetna Better Health were found to be underestimated when compared to the numbers validated by the EQRO. Whereas, the numbers reported by Home State Health and Missouri Care were found to be overestimated when compared to the numbers validated by the EQRO.

Figure 9 – Statewide Comparison for EDV – Behavioral Health measure.



	Aetna Better Health 2015	Aetna Better Health 2016	Home State Health 2015	Home State Health 2016	Missouri Care 2015	Missouri Care 2016
Validated	3,408	3,655	693	17	1,207	733
Reported	2,625	2,552	1,128	771	1,216	1,394

Source: BHC, Inc., 2015 and 2016 External Quality Review Performance Measure Validation.

The difference in rates reported and validated for Aetna Better Health are consistent over the past two years. In 2015 an underestimate of 0.36% was found; and in 2016, an underestimate of 0.45% was found. The EQRO cannot be certain of the reason for the differences between the rates of hits; however, the data provided for validation did not produce the number of hits reported by the MCHP for the second year in a row. The EQRO believes it is imperative that the MCHP work with the EQRO and MO HealthNet to discuss any differences in expectations for the reported data.

For the 2016 review, Home State Health supplied the EQRO with a numerator file that contained a total of 17 records. The EQRO validated those 17 records, but was not supplied with any additional data for this measure by the MCHP. Home State reported 771 hits to MO HealthNet for the EDV-Behavioral Health measure. Therefore, the EQRO found an overestimate of 0.78%. This is comparable to the results of the 2015 review, where the EQRO validated 693 hits of the 1,128 hits submitted by Home State Health. This difference represented an overestimate of 0.61%. As in 2015, the EQRO is certain that the data provided by Home State was not capable of producing the hits reported MO HealthNet. The EQRO believes that the MCHP would benefit from a discussion with the EQRO about what data are expected.

Although Missouri Care reported a total of 1,394 EDV-Behavioral Health hits, the MCHP supplied three files that contained a total of 733 records containing a mental health diagnosis. Of these 733 records, 153 contained an inpatient admit date and these records could not be validated, as the technical specifications for the Healthcare Data Quality Report instructs the MCHP to "only include observation stays that do not result in an inpatient stay." Additionally, 197 records submitted by Missouri Care did not contain a service code or procedure code. The data submitted to the EQRO was not capable of producing the number of hits reported to MO HealthNet. Therefore, the EQRO concludes that the Healthcare Data Quality Report does not represent an accurate representation of the number of Missouri Care Emergency Department visits that were supplied for members with a behavioral health diagnoses.

Emergency Department Visits for Substance Abuse Diagnoses

The calculation of the EDV-Substance Abuse measure is based on the Identification of Alcohol and Other Drug Services (IAD) measure from the HEDIS 2016 Technical Specifications. The IAD measure is designed to count all visits made by members with an alcohol and other drug claim who received chemical dependency services in an Emergency Department (ED) setting and to only include observation stays that do not result in an inpatient stay. All visits for this measure are required to have a valid chemical dependency diagnosis. Additionally, the place of service (POS) for all ED services was limited to the acceptance of only the POS=23 code, which indicates the service occurred in the ED.

Table 12 - Data Submission & Final Validation - 2015 EDV Substance Abuse report (combined rate).

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate calculated from hits reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	241146	521	0.22%	701	0.29%	-0.07%
Home State Health	74890	192	0.26%	220	0.29%	-0.04%
Missouri Care	102918	267	0.26%	253	0.25%	0.01%
Total	418954	980	0.23%	1174	0.28%	-0.05%

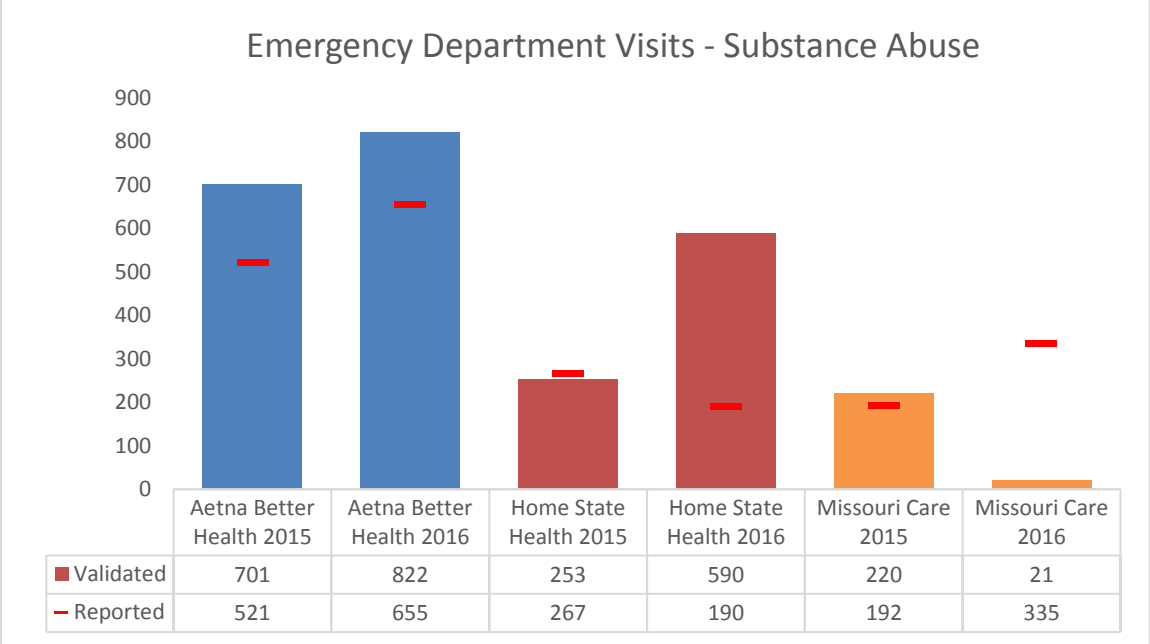
Note: NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc); Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP - Rate Validated by EQRO. Positive bias indicates an overestimate. **Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2014.**

Table 13 - Data Submission & Final Validation - 2016 EDV Substance Abuse report (combined rate).

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate calculated from hits reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	243691	655	0.27%	822	0.34%	-0.07%
Home State Health	96949	190	0.20%	590	0.61%	-0.41%
Missouri Care	114706	335	0.29%	21	0.02%	0.27%
Total	455346	1180	0.26%	1436	0.32%	-0.06%

Note: NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc); Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP - Rate Validated by EQRO. Positive bias indicates an overestimate. **Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2015.**

Figure 10 – Statewide Comparison for EDV – Substance Abuse measure.



Source: BHC, Inc., 2015 and 2016 External Quality Review Performance Measure Validation.

For the 2016 review, the difference of 167 records reported by Aetna Better Health shows an underestimate of 0.07% in the calculations. This is consistent with the 2015 validation where a difference of 180 hits was an underestimate of 0.07% which is much closer to the rate validated than the other sub-measures (EDV - Medical and Behavioral Health). However, the EQRO cannot be certain of the reason for the differences between the two rates of hits. The EQRO is certain that the data provided for validation did not produce the number of hits reported by the MCHP.

For the 2016 review, Home State Health supplied the EQRO with a numerator file that contained a total of 593 records. The EQRO validated 590 records, as three of those records contained an ED Place of Service Code = 22 and were not valid. Home State Health reported 190 hits to MO HealthNet for this measure. Therefore, an underestimate of 0.41% was found. In 2015, the EQRO validated 220 hits, whereas the MCHP submitted 192 hits to MO HealthNet for the EDV-Substance Abuse measure. This difference represented an underestimate of 0.04%; and the EQRO was uncertain of the reason for the differences between the numbers of hits. For the 2016 review, the EQRO believes that Home State did not provide the same data in response to the EQRO's data request as it did to MO HealthNet. Additionally, Home State Health supplied the same numbers for the EDV measures (a count of total ED visits) as it did for the EDU measures (a count of each member who made an ED visit) on the Healthcare Data Quality Template report. The EQRO assumes Home State Health submitted some "part" of the requested totals for the Healthcare Data Quality Template to MO HealthNet, possibly data for one region or age stratification.

Although Missouri Care reported a total of 335 EDV-Substance Abuse hits, the MCHP supplied three files that contained a total of 40 records with a Chemical Dependency diagnosis. Of these 40 records, three contained an inpatient admit date. These records could not be validated, as the technical specifications for the Healthcare Data Quality Report instructs the MCHP to "only include observation stays that do not result in an inpatient stay." Additionally, 16 records submitted by Missouri Care did not contain a service code or procedure code. The data submitted to the EQRO was not capable of producing the number of hits reported to MO HealthNet; and therefore, the EQRO concludes that the Healthcare Data Quality Report does not represent an accurate representation of the number of Missouri Care Emergency Department visits that were supplied for substance abuse diagnoses.

Due to the inability of the EQRO to validate most of the hits claimed by two of the MCHPs, these two MCHPs did not meet all validation elements for the processes used to produce numerators. One MCHP (Aetna Better Health) did substantially meet those validation elements regarding accuracy and completeness of data sources for the numerator, as the estimated bias found for Aetna Better Health's data was less than one percent for all three sub measures.

2016 Emergency Department Utilization (EDU)

The EDU measure is an Access to Care measure. The EDU measure reflects the percentage of members who had at least one emergency department visit that occurred during the measurement year. These visits are then stratified by age and presenting diagnosis (Behavioral Health; Medical; or Substance Abuse).

The calculation of the EDU-Medical measure is based upon the Ambulatory Care (AMB) measure from the HEDIS 2016 Technical Specifications. The AMB specifications require a count of every visit to an Emergency Department that does not result in an inpatient stay, regardless of the duration or intensity of the visit. The measure was calculated by taking the EDV-Medical result set and counting one visit for each unique member, and was modified by sorting the results into age groupings as specified by MO HealthNet. The EDU-Medical measure does NOT include emergency department visits for any mental health or chemical dependency diagnoses or service.

The calculation of the EDU-Behavioral Health measure is based on the Mental Health Utilization (MPT) measure from the HEDIS 2016 Technical Specifications. The MPT measure is designed to count all visits made by members who received mental health services in an Emergency Department (ED) setting. The measure was calculated by taking the EDV- Behavioral Health result set and counting one visit for each unique member, and was modified to separate Outpatient and ED visits. All visits for this measure are required to have a valid mental health diagnosis. Additionally, the place of service (POS) for all ED services was limited to the acceptance of only the POS=23 code, which indicates the service occurred in the ED.

The calculation of the EDU-Substance Abuse measure is based on the Identification of Alcohol and Other Drug Services (IAD) measure from the HEDIS 2016 Technical Specifications. The IAD measure is designed to count all visits made by members with an alcohol and other drug claim who received chemical dependency services in an Emergency Department (ED) setting. The measure was calculated by taking the EDV- Substance Abuse result set and counting one visit for each unique member. All visits for this measure are required to have a valid chemical dependency diagnosis. Additionally, the place of service (POS) for all ED services was limited to the acceptance of only the POS=23 code, which indicates the service occurred in the ED.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MCHPs' ability to accurately identify medical events, evaluate the MCHP's ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. Table 15 shows the number of EDUs reported with a primary medical diagnosis to MO HealthNet in the June 30, 2016 Healthcare Data Quality Template report, and the number of EDUs validated by the EQRO based on the data supplied to the EQRO by the MCHPs in March 2017 and November 2017.

Emergency Department Utilization for Medical diagnoses

Table 14 - Data Submission and Final Validation - 2015 EDU Medical report (combined rate).

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate calculated from hits reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	241146	106092	43.99%	107060	44.40%	-0.40%
Home State Health	74890	30337	40.51%	30091	40.18%	0.33%
Missouri Care	102918	42244	41.05%	42290	41.09%	-0.04%
Total	418954	178673	42.65%	179441	42.83%	-0.18%

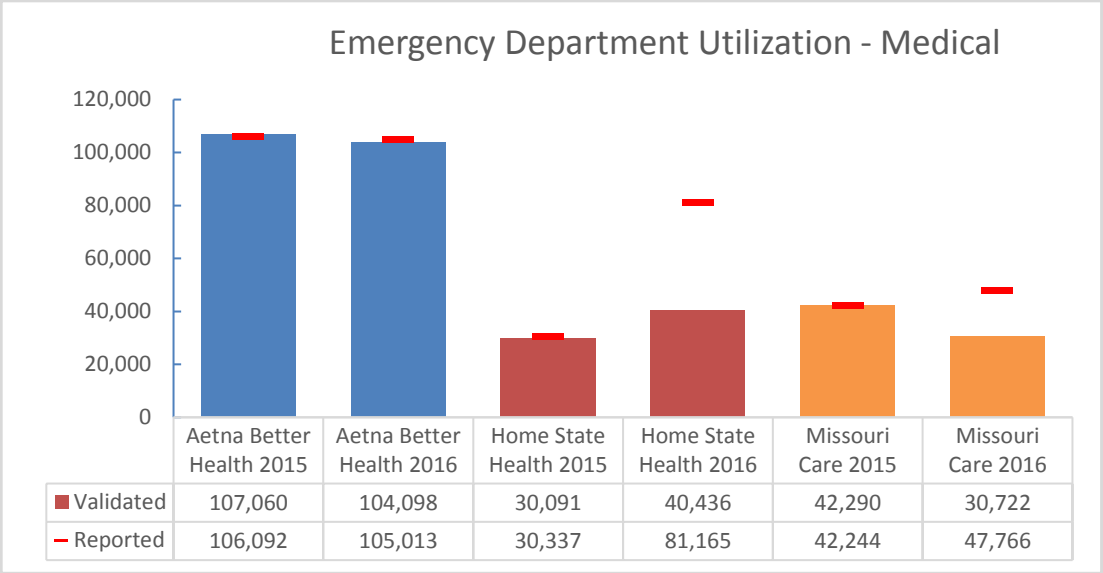
Note: NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc); Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP - Rate Validated by EQRO. Positive bias indicates an overestimate. **Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2014.**

Table 15 - Data Submission and Final Validation - 2016 EDU Medical report (combined rate).

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate calculated from hits reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	243691	105013	43.09%	104098	42.72%	0.38%
Home State Health	96949	81165	83.72%	40436	41.71%	42.01%
Missouri Care	114706	47766	41.64%	30722	26.78%	14.86%
Total	455346	233944	51.38%	175256	38.49%	12.89%

Note: NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc); Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP - Rate Validated by EQRO. Positive bias indicates an overestimate. **Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2015.**

Figure 11 – Statewide Comparison for EDU – Medical measure.



	Aetna Better Health 2015	Aetna Better Health 2016	Home State Health 2015	Home State Health 2016	Missouri Care 2015	Missouri Care 2016
Validated	107,060	104,098	30,091	40,436	42,290	30,722
Reported	106,092	105,013	30,337	81,165	42,244	47,766

Source: BHC, Inc., 2016 External Quality Review Performance Measure Validation.

For the 2016 review, the EQRO found a difference of 915 hits between the reported and validated hits for Aetna Better Health, and this is an overestimate of 0.38%. This is consistent with the 2015 validation when a difference of 968 hits was an overestimate of 0.40%. These differences are attributed to an incorrect calculation in the data submitted to MO HealthNet or an incorrect data submission to the EQRO. The EQRO believes it is imperative that the MCHP work with the EQRO and MO HealthNet to discuss any differences in expectations for the reported data.

For the 2016 review, Home State Health supplied a total of 81,133 records for the EQRO to analyze. Of those, 40,436 were found to be EDU-Medical hits. Home State reported 81,165 EDU-Medical hits to MO HealthNet. This is a difference of 40,729 hits and an overestimate of 42.01%. In 2015, a difference of 246 hits and an underestimate of 0.33% was observed. In 2015, this discrepancy was attributed to an incorrect calculation in the data submitted to MO HealthNet or an incorrect data submission to the EQRO. However, for the 2016 report, the EQRO is certain that the data submissions received by the EQRO and the report submitted to MO HealthNet were inaccurate. Home State Health supplied the same numbers for the EDV measures (a count of total ED visits) as it did for the EDU measures (a count of each member who made an ED visit) on the Healthcare Data Quality Template report.

Missouri Care provided three numerator files (one for each MCHP region), and the total number of records contained in these files was 49,184. The EQRO could validate 30,722 EDU-Medical hits from these files. Conversely, in 2015, the EQRO was only able to find a difference of 46 records in Missouri Care's submission. For the 2016 review, there were 742 Missouri Care submitted records that contained an "Inpatient Admission Date," and 17,186 records that did not contain a service code or procedure code to validate that the service was an approved ER service. The number of incorrect data submitted by Missouri Care calls in to question the accuracy of the data originally submitted for the Healthcare Quality Data Template.

Emergency Department Utilization for Behavioral Health diagnoses

Table 16 - Data Submission & Final Validation - 2015 EDU Behavioral Health report (combined rate).

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate calculated from hits reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	216151	2172	1.00%	2311	1.07%	-0.06%
Home State Health	71476	867	1.21%	531	0.74%	0.47%
Missouri Care	97996	989	1.01%	975	0.99%	0.01%
Total	385623	4028	1.04%	3817	0.99%	0.05%

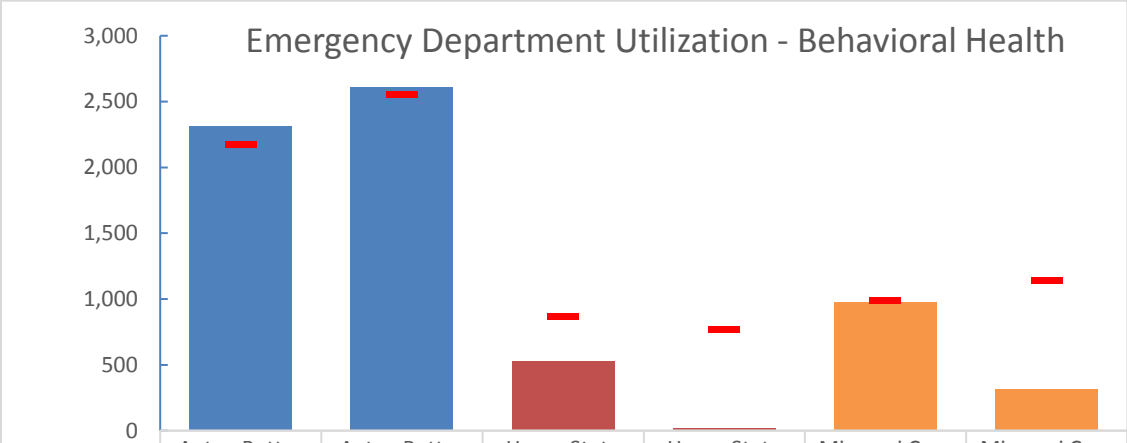
Note: NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc); Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP - Rate Validated by EQRO. Positive bias indicates an overestimate. **Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2014.**

Table 17 - Data Submission & Final Validation - 2016 EDU Behavioral Health report (combined rate).

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate calculated from hits reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	243691	2552	1.05%	2611	1.07%	-0.02%
Home State Health	96949	771	0.80%	17	0.02%	0.78%
Missouri Care	114706	1140	0.99%	315	0.27%	0.72%
Total	455346	4463	0.98%	2943	0.65%	0.33%

Note: NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc); Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP - Rate Validated by EQRO. Positive bias indicates an overestimate. **Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2015.**

Figure 12 – Statewide Comparison for EDU – Behavioral Health measure.



	Aetna Better Health 2015	Aetna Better Health 2016	Home State Health 2015	Home State Health 2016	Missouri Care 2015	Missouri Care 2016
Validated	2,311	2,611	531	17	975	315
Reported	2,172	2,552	867	771	989	1,140

Source: BHC, Inc., 2015 and 2016 External Quality Review Performance Measure Validation.

For the 2016 review, Aetna Better Health reported a difference of 59 records or an underestimate of 0.02%. This is an improvement over the 2015 difference of 139 hits, which was an underestimate of 0.06%. The EQRO attributes the MCHP's underestimates to incorrect calculation or identification of variables in the data submitted to MO HealthNet. However, this calculation is more accurate than most of the data submitted for the EDV and EDU measures.

For the 2016 review, Home State Health provided a file that contained only 17 records for the EDU-Behavioral Health visits measure, and the EQRO validated all 17 records. However, Home State Health reported 771 EDU-Behavioral Health hits to MO HealthNet. This difference of 754 records is an overestimate of 0.78%. This is comparable to the 2015 findings for the EDU-behavioral health measure. A difference of 336 EDU-Behavioral Health hits was an overestimate of 0.47%. The 2016 overestimate is directly attributable to an incorrect data submission to the EQRO.

In 2015, Missouri Care provided a file containing 81,159 records. The EQRO found 975 hits in the records, and this was a difference of only 14 records from the reported total number of EDU-Behavioral Health hits of 989. However, in 2016, a difference of 825 records was found by the EQRO. This difference was an overestimate of the number of EDU-Behavioral Health hits. This was due to the records that contained inpatient admission dates and 202 records that did not contain a service code or procedure code.

Emergency Department Utilization for Substance Abuse diagnoses

Table 18 - Data Submission & Final Validation - 2015 EDU Substance Abuse report (combined rate).

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate calculated from hits reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	241146	417	0.17%	423	0.18%	0.02%
Home State Health	74890	169	0.23%	126	0.17%	0.06%
Missouri Care	102918	216	0.21%	216	0.21%	0.00%
Total	418954	802	0.19%	765	0.18%	0.01%

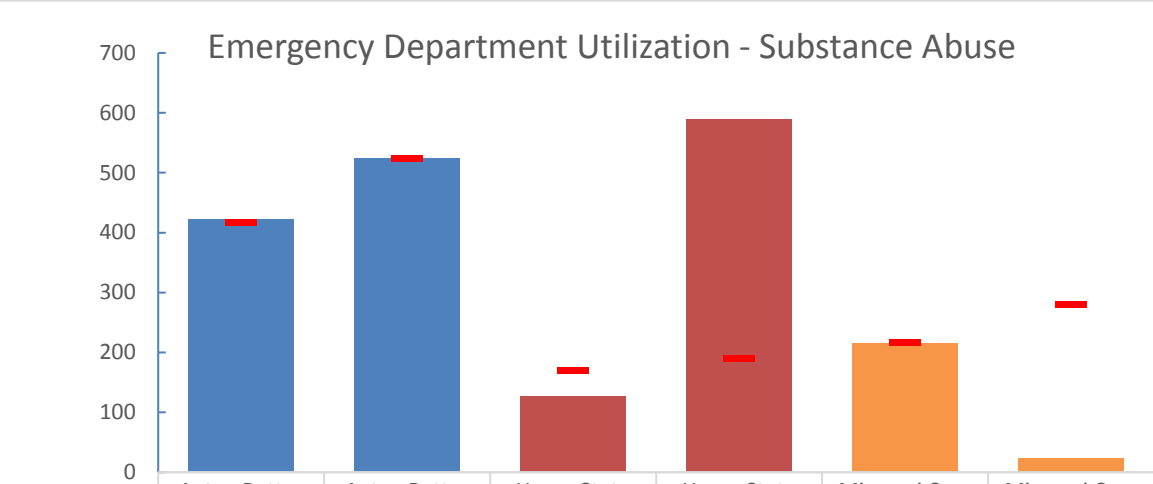
Note: NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc); Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP - Rate Validated by EQRO. Positive bias indicates an overestimate. **Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2014.**

Table 19 - Data Submission & Final Validation - 2016 EDU Substance Abuse report (combined rate).

Managed Care Health Plan	Eligible Population	Number of Hits Reported by MCHP	Rate calculated from hits reported by MCHP	Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Aetna Better Health	243691	524	0.22%	524	0.22%	0.00%
Home State Health	96949	190	0.20%	590	0.61%	-0.41%
Missouri Care	114706	280	0.24%	23	0.02%	0.22%
Total	455346	994	0.22%	1137	0.25%	-0.03%

Note: NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc); Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP - Rate Validated by EQRO. Positive bias indicates an overestimate. **Source: MCHPs' Measures to be Reported to MO HealthNet by Managed Care Plans: Data Year 2015.**

Figure 13 – Statewide Comparison for EDU – Substance Abuse measure.



	Aetna Better Health 2015	Aetna Better Health 2016	Home State Health 2015	Home State Health 2016	Missouri Care 2015	Missouri Care 2016
Validated	423	524	126	590	216	23
Reported	417	524	169	190	216	280

Source: BHC, Inc., 2015 and 2016 External Quality Review Performance Measure Validation.

During the 2015 review, the EDU-Substance Abuse visits sub measure was more accurately reported than any of the other measures validated by the EQRO. However, due to inaccurate submissions by both Home State and Missouri Care, this did not hold true for the 2016 review.

In 2016, Aetna Better Health was the only MCHP to report the same number of hits that were validated by the EQRO, thereby showing no bias in their reporting for this sub measure. In 2015, Aetna Better Health reported a difference of 6 hits. This overestimate of 0.02% was attributed to an incorrect calculation in the data submitted to MO HealthNet or an incorrect data submission to the EQRO.

However, for the 2016 report, the EQRO is certain that the data submissions received from Home State Health and the report submitted to MO HealthNet were both inaccurate. Home State Health reported 190 EDU-Substance Abuse hits, and the EQRO validated 590 hits in the file received. This is due to Home State Health supplying the same numbers for the EDV measures (a count of total ED visits) as it did for the EDU measures (a count of each member who made an ED visit) on the Healthcare Data Quality Template report. Therefore, the EQRO must find their submission to be invalid.

The 2016 Missouri Care submission contained a difference of 267 records from what was provided to MO HealthNet in the Healthcare Data Quality Template report. This difference was an overestimate of the number of EDU-Substance Abuse hits. This was due to the records that contained inpatient admission dates and 15 records that did not contain a service code or procedure code. Therefore, the EQRO must find their submission to be invalid.

Two MCHPs (Home State Health and Missouri Care) did not meet all the validation requirements for the process used to produce numerators. These MCHPs failed to provide accurate and complete data sources for the numerator. Aetna Better Health was the only MCHP to produce a measure that contained no bias when recalculated and validated by the EQRO.

3.3 Conclusions

In the measures calculation, all the MCHPs have adequate information systems for capturing and storing enrollment, eligibility, and claims information for the calculation of the three measures validated. However, two MCHPs (Home State Health and Missouri Care) were unable to pull the information as requested from their information systems to enable the EQRO to recalculate the EDV and EDU measures consistently. Although clearly articulated in a data request, both Home State Health and Missouri Care have been unsuccessful in providing the data requested by both the EQRO and MO HealthNet. These MCHPs would both benefit from a discussion with the EQRO about the expectations and specifics of the data being validated.

Among MCHPs, there was good documentation of the HEDIS 2016 rate production process. The rate of medical record submission for the one measure allowing the use of the Hybrid Methodology was 100%; and the EQRO received all the medical records requested. This review also marked the fourth review year in which all contracted MCHPs performed a hybrid review of the measure selected, allowing for a complete statewide comparison of those rates.

QUALITY OF CARE

This is the second year to audit the EDU measure. This measure serves to provide a count of the individual number of members who access the ED for various issues, over the course of the measurement year. This measure provides further detail as to the reason for the ED visit, categorizing it as Medical, Behavioral Health, or Substance Abuse. This information is useful for the MCHPs to determine if the ED is being utilized properly by its members. The MCHPs can also use this information to ensure that the quality of care necessary for members is available in the ED for the non-medical categories.

One MCHP (Aetna Better Health) received a rating of Substantially Compliant with the specifications for calculation of this measure (See Table 5). The EQRO is confident in the rate validated for Aetna Better Health in the behavioral health and substance abuse sub measures, as these rates had an estimated bias of 0.02% or less. The EQRO is not confident in both the Home State Health and Missouri Care rates as neither MCHP's data could be recalculated to match the numbers reported to MO HealthNet.

Access to Care

The EDV measure is intended to measure the number of ED visits recorded for the MCHP. Members need only one qualifying visit from any appropriate provider to be included in this measure calculation. This measure provides further detail to the reason for the ED visit, categorizing it as Medical, Behavioral Health, or Substance Abuse.

Two MCHPs (Home State Health and Missouri Care) had the EDV measure rated as Not Valid by the EQRO. Both MCHPs' submissions contained data that did not match the specifications for calculating the measures. Only Aetna Better Health supplied records that were consistent with the measure specifications. When analyzed, these records produced results that were in line with the reported number of hits.

Timeliness of Care

The HEDIS 2016 Prenatal and Postpartum measure is categorized as an Access/Availability of Care measure and aims to measure the access to and timeliness of the care received. To increase the rates for this measure, members must receive a visit within a specific timeframe (i.e., in the first trimester or between 21 and 56 days of delivery).

All three MCHPs validated by the EQRO were Fully Compliant with the specifications for calculation of this measure. The MCHPs were all consistent with or exceeded the National Medicaid Average of 61.79% for the Postpartum measure. However, all MCHPs fell short of the National Medicaid Average of 82.43% for the Prenatal measure. This was the first year that PPC had been audited since 2006.

Recommendations

1. MO HealthNet should continue to encourage the use of the Hybrid Method of calculation for HEDIS measures that allow these reviews. The Hybrid review process produces higher rates on average than an Administrative method alone.
2. MO HealthNet should continue to have the EQRO validate the calculation of at least one measure from year to year, for the purposes of comparison and analysis of trend data.
3. The MCHPs should submit data in response to data requests in the format requested. Additional data is not necessary and can hamper the validation. Not submitting data as requested contributed to the invalid ratings for EDV and EDU.

4. MCHPs should continue to examine their efforts in the PPC measure, especially in Prenatal Care where none of the MCHPs were able to exceed the National Medicaid Average rate.
5. MCHPs should consider expanding their Case Management programs to target some of the other population categories tied to HEDIS Performance Measures. Dental visits and Childhood Immunization Status could benefit from such targeting, similar to how PPC has benefitted from the requirement of offering case management to all pregnant members.

4.0 COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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4.1 Purpose and Objectives

The External Quality Review (EQR) is conducted annually in accordance with the "Medicaid Program: External Quality Review of the Medicaid Managed Care Organizations Final Rule, 42 CFR 438, Subpart E." The EQRO uses the Assessment of Compliance with Medicaid Managed Care Regulations (Compliance Protocol) requirements during the review process, with an emphasis on areas where individual MCHPs have previously failed to comply or were partially compliant at the time of the prior reviews. Specifically, the MCHPs were reviewed to assess their compliance with the federal Medicaid managed care regulations; the State Quality Strategy; the MO HealthNet Managed Care contract requirements; and the progress made in achieving quality, access, and timeliness to services from the previous review year.

This year's review (calendar year 2016) is the first of two follow-up compliance reviews and will have one additional follow-up year – 2017. This year's review includes follow-up to any non-compliant components of the Quality Standards as defined in 42 CFR 438. Evaluation of these components included the reviews of:

- Defined organizational structure with corresponding committee minutes
- Policies and Procedures
- Organizational protocols
- Print materials available to members and providers
- Report results
- Staff interviews

MO HealthNet reviewed submitted policies and procedures at each MCHP to ensure that they followed contractual requirements and federal regulations. The EQRO conducted on-site reviews to verify that those policies and procedures reflect the everyday practice of the MCHPs.

During this compliance review, the EQRO conducted a special project to review the MCHPs' compliance with federal regulations regarding quality, timeliness, and access to health care services related to the provision of case management services. The objective of this special project is to complete a review of Case Management by assessing the MCHPs' service delivery and record keeping. The EQRO also evaluated the MCHPs' compliance with the federal regulations and the Managed Care contract as it pertained to Case Management.

Obtaining Background Information from the State Medicaid Agency

Interviews and meetings occurred as needed with individuals from MO HealthNet from February 2017 through June 2017 to obtain relevant information for the on-site visits.

Document Review

Documents chosen for review were those that best demonstrated each MCHP's ability to meet federal regulations. Certain documents, such as the Member Handbook, provided evidence of communication to members about a broad spectrum of information including enrollee rights and the grievance and appeal process. Managed Care contract compliance worksheets and case management policies were reviewed as a basis for interview questions that made up the focus of the 2016 Compliance Review. The Annual Quality Assessment and Improvement Evaluation was requested and reviewed to provide insight into each MCHPs' compliance with the requirements of MO HealthNet Quality Improvement Strategy; an essential component of the Managed Care contract and is required by the federal regulations. MCHPs' Quality Improvement Committee meeting minutes were reviewed. Grievance and Appeal policies and procedures were reviewed and used in discussions with MCHP staff.

The following documents were reviewed for all MCHPs:

- State contract compliance ratings from 2016 and updated policies accepted through June 2017;
- Results, findings, and follow-up information from the 2015 External Quality Review; and
- 2016 MCHP Annual Quality Assessment and Improvement Evaluation.

Conducting Interviews

After discussions with MO HealthNet, it was decided that the 2016 Compliance Review would include interviews with Case Management Staff (under the guidelines of the "Special Project") and Administrative Staff. The goal of these interviews was to validate that practices at the MCHPs, particularly those directly affecting members' access to quality and timely health care, followed the approved policies and procedures. The questions were developed to seek concrete examples of activities and responses that would validate that these activities are compliant with contractual requirements and federal regulations.

Interviews were held at Missouri Care and Home State Health with case management and administrative staff to obtain clarification on issues identified from the policy and document reviews, and to clarify some responses received from the case managers. Case Management interview questions were developed from the review of each MCHP's case management policy, and from the case records reviewed prior to the time of the on-site review. Administrative interview questions were developed from the review of each MCHP's Annual Report, Member Handbook, and Quality Committee meeting minutes. These interview questions were specific to each MCHP, and focused on issues that might compromise compliance with required case management or administrative activities. The specific findings of the Case Management interviews are reported in the "Special Project" section of this report.

The interviews provided reviewers with the opportunity to explore issues not addressed in the documentation. Site visit questionnaires specific to Missouri Care and Home State Health were developed.

Analyzing and Compiling Findings

The review process included gathering information and documentation from MO HealthNet about policy submission and approval, which directly affects each MCHP's contract compliance. This information was analyzed to determine how it is related to compliance with the federal regulations. The interview responses and additional documentation obtained on-site were then analyzed to evaluate how they contributed to each MCHP's compliance. All information gathered was assessed, re-reviewed, and translated into recommended compliance ratings for each regulatory provision.

Reporting to the State Medicaid Agency

Discussion occurred with MO HealthNet staff to confirm that a sound rationale was used in rating determinations. MO HealthNet approved the process and allowed the EQRO to finalize the ratings for each regulation. The actual ratings are included in this report.

Compliance Ratings

The EQRO utilizes a Compliance Rating System that was developed during previous reviews (see below). The determinations found in the Compliance Ratings considered contract

compliance, review findings, MCHP policy, ancillary documentation, and staff interview summary responses related to MCHP practices observed on-site.
If MO HealthNet considered the policy submission valid and rated it as complete, this rating was used unless practice or other information called this into question. If this conflict occurred, it was explained in the narrative included in the individual MCHPs Compliance Section.

After completing the initial document review, it was clear that the MCHPs have developed appropriate and compliant written policies and procedures. The findings in Section 4.2 detail the EQRO's assessment of each MCHP's adherence to these written policies and procedures.

The scale allowed for credit when a requirement was Partially Met. Ratings were defined as follows:

Met:	All documentation listed under a regulatory provision, or one of its components was present. MCHP staff could provide responses to reviewers that were consistent with one another and the available documentation. Evidence was found and could be established that the MCHP was in full compliance with regulatory provisions.
Partially Met:	There was evidence of compliance with all documentation requirements; but staff was unable to consistently articulate processes during interviews; or documentation was incomplete or inconsistent with practice.
Not Met:	Incomplete documentation was present; and staff had little to no knowledge of processes or issues addressed by the regulatory provision.

4.2 Findings

Enrollee Rights and Protections

Subpart C of the regulatory provisions for Medicaid managed care (Enrollee Rights and Protections) sets forth 13 requirements of MCHPs addressing provision of information to enrollees in an understandable form and language; written policies regarding enrollee rights and assurance that staff and contractors take them into account when providing services; and requirements for payment and no liability of payment for enrollees. Across all MCHPs, 100% of the regulations were rated as "Met." This is comparable to the 2015, 2014, 2013 and 2012 review years.

All MCHPs had procedures in place to ensure that members receive pertinent and approved information [438.100(a) and 438.10(b)]; that they were addressed in their prevalent language [438.10(c)(3)]; that they have access to required interpreter services [438.10(c)(4,5)]; that all

information is provided in an easily understood format [438.10 (d)(1)(i)/438.10(d)(1)(ii) & (2)]; that they are treated with respect and dignity and receive information on available treatment options and alternatives [438.100(b)(2)(iii)/438.10(g)]; and that the MCHPs are in compliance with other state requirements [438.100(d)]. All MCHP's were found to have practices that met these requirements.

All MCHPs continued to operate programs for the provision of behavioral health services. All MCHPs utilize an "in-house" model for the provision of behavioral health services. Each MCHP has a BHO that is part of their parent company's structure.

Quality Assessment and Performance Improvement: Access Standards

Subpart D of the regulatory provision for Medicaid managed care sets forth 17 regulations governing access to services. These regulations call for: the maintenance of a network of appropriate providers including specialists, the ability to access out-of-network services in certain circumstances, adequate care coordination for enrollees with special healthcare needs, development of a method for authorization of services within prescribed timeframes, and the ability to access emergency and post-stabilization services. Across all MCHPs, the rate of regulations "Met" for the 2016 review (72.55%) is consistent with the 2015 review, but lower than the prior two years' review rates: 2014 (78.43%) and 2013 (74.51%). One MCHP (Home State Health) was found to be 82.35% compliant, Missouri Care was found to be 70.59% compliant, and Aetna Better Health was 64.71% compliant.

- Home State Health improved over their prior year rates of 76.47% in 2015 and 2014 and 70.59% in 2013.
- Aetna Better Health saw a decrease from all prior year rates, with their 2014 and 2015 rates of 76.47% and their 2013 rate of 82.35%.
- Missouri Care saw an increase from their 2015 rate of 64.71%, and a decrease from their 2014 and 2013 rates (82.35% and 70.59% respectively).

The rating for the Access Standards compliance rate is directly attributable to the findings of the Case Management Special Project, and a website accuracy and secret shopper survey the EQRO conducted for MO HealthNet. Further information regarding the Case Management Special

Project may be reviewed in Section 5 of this report. Further information regarding the Website Accuracy Survey may be found at http://dss.mo.gv/mhd/mc/pdf/health-plan-website-accuracy-new-patient-acceptance-rates-report.pdf. However, it is worth noting that during the secret shopper survey, the EQRO found that 45% of all MCHP PCPs who were listed as taking new patients were, in fact, not taking new patients. This is a slight increase over the 42% who were not taking new patients during the 2015 survey.

All MCHPs had policies and practice that reflected the members' right to a second opinion and a third opinion if the first two disagreed [438.206(b)(3)]. Other areas where all MCHPs were 100% compliant with complete and approved policy were Adequate and Timely Service and Cost Sharing for Out of Network Services; Timely Access to Care, Provider Cultural Competency; Timeframes for Decisions for Expedited Authorizations; and Emergency and Post-Stabilization Services. Throughout this review period, all MCHPs reported incidents where they found providers who were familiar with members' cultural and language needs. Sensitivity to and respect for members' cultural needs was an area where the MCHPs excelled.

Table 20 - Subpart D: Quality Assessment and Performance Improvement: Access Standards.

Federal Regulation	MO HealthNet MCHP			All MO HealthNet MCHPs			
	Aetna Better Health	Missouri Care	Home State Health	Number Met	Number Partially Met	Number Not Met	Rate Met
438.206(b)(1)(i-v) Availability of Services: Provider Network	0	0	0	0	0	3	0%
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2	3	0	0	100%
438.206(b)(3) Second Opinions	2	2	2	3	0	0	100%
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2	3	0	0	100%
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2	3	0	0	100%
438.206(c)(1)(i-vi) Timely Access	2	2	2	3	0	0	100%
438.206(c)(2) Provider Services: Cultural Competency	2	2	2	3	0	0	100%
438.208(b) Care Coordination: Primary Care	1	0	2	1	1	1	33.3%
438.208(c)(1) Care Coordination: Identification	1	2	1	1	2	0	33.3%
438.208(c)(2) Care Coordination: Assessment	1	1	2	1	2	0	33.3%
438.208(c)(3) Care Coordination: Treatment Plans	1	1	2	1	2	0	33.3%
438.208(c)(4) Care Coordination: Direct Access to Specialists	1	1	1	0	3	0	0.0%
438.210(b) Authorization of Services	2	2	2	3	0	0	100%
438.210(c) Notice of Adverse Action	2	2	2	3	0	0	100%
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2	3	0	0	100%
438.210(e) Compensation of Utilization Management Activities	2	2	2	3	0	0	100%
438.114 Emergency and Post-Stabilization Services	2	2	2	3	0	0	100%
Number Met	11	12	14	**37**	**10**	**4**	**72.55%**
Number Partially Met	5	3	2				
Number Not Met	1	2	1				
Rate Met	64.71%	70.59%	82.35%				

Note: 0 = Not Met; 1= Partially Met; 2 = Met **Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2012). Assessment of Compliance with Medicaid Managed Care Regulations, Protocol 1, v. 2.0, September 1, 2012; BHC, Inc., 2016 External Quality Review Monitoring MCHPs Protocols.**

Evidence existed of efforts to inform members of available providers, urgent care centers, and hospitals through presentations at community events and newsletters. In Care Coordination, both Aetna Better Health and Home State Health increased the number of standards that were fully met, whereas Missouri Care reduced the number of standards that were fully met. Required documentation and approved policies did exist in all areas for all MCHPs. All the MCHPs had complete policy and Provider Manual language in emergency and post-stabilization services [438.114].

Quality Assessment and Performance Improvement: Structure and Operations Standards

There are 10 Structure and Operations Standards for ensuring compliance with State policies and procedures for the selection and retention of providers, disenrollment of members, grievance systems, and accountability for activities delegated to subcontractors. Across all MCHPs, 100% of the regulations were rated as "Met." This is consistent with the 2015, 2014, and 2013 review year ratings of 100% compliance.

It was evident through on-site interviews that the Provider Services departments of the MCHPs exhibited a sound and thorough understanding of the requirements for provider selection, credentialing, nondiscrimination, exclusion, and Managed Care requirements. All the MCHPs were 100% compliant with these regulations. This included Provider Selection [438.214(d) and 438.214(e)]; timeframes [438.56(e)]; and disenrollment. The staff interviewed at each MCHP understood the requirements for disenrollment. All the MCHPs described credentialing and re-credentialing policies that exceeded the requirements of the regulations. All MCHPs have developed policy and procedures that comply with NCQA criteria. Providers were willing to submit to these stricter standards to maintain network qualifications in both the MCHPs and other commercial networks. All the MCHPs (100.0%) had all required policies and practices in place regarding credentialing.

Quality Assessment and Performance Improvement: Measurement and Improvement

There are 12 Measurement and Improvement Standards addressing the selection, dissemination, and adherence to practice guidelines; the implementation of PIPs; the calculation of performance measures; the evaluation of the availability of services and assessment techniques for enrollees with special healthcare needs; and the maintenance of information systems that can be effectively used to examine service utilization, grievances and appeals, and disenrollment. A total of 84.85% of the criteria were "Met" by the MCHPs which is consistent with the 2015 rate and a decrease from the 2014 of 97.0% of the criteria being "Met" by the MCHPs.

Aetna Better Health improved from a rate of 81.8% in 2015 to 100% in 2016; and Home State Health remained consistent at 81.8% of the requirements met in this area. Missouri Care saw a decrease from their rate of 90.9% in 2015 to 81.8% in 2016. These ratings were affected by a

change in the rating for the Performance Measures standard in this area. This was attributed to the EQRO's inability to validate data provided for the EDV and EDU measures. More information regarding these issues can be found in Section 3 of this report. Additionally, two MCHPs received a "Partially Met" rating in Performance Improvement Projects (PIPs) as they had not reached a rating of 100% for all their PIPs.

Table 21 - Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement.

Federal Regulation	MO HealthNet MCHP						
	Aetna Better Health	Home State Health	Missouri Care	Number Met	Number Partially Met	Number Not Met	Rate Met
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2	3	0	0	100%
438.236(c) Practice Guidelines: Dissemination	2	2	2	3	0	0	100%
438.236(d) Practice Guidelines: Application	2	2	2	3	0	0	100%
438.240(a)(1) QAPI: General Rules	2	2	2	3	0	0	100%
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCHP Quality Improvement and PIPs	2	1	1	1	2	0	33.3%
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	1	1	1	0	3	0	0%
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2	3	0	0	100%
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2	3	0	0	100%
438.240(e) QAPI: Program Review by State	NA	NA	NA	NA	NA	NA	NA
438.242(a) Health Information Systems	2	2	2	3	0	0	100%
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2	3	0	0	100%
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2	3	0	0	100%
Number Met	10	9	9	**28**	**5**	**0**	**84.85%**
Number Partially Met	1	2	2				
Number Not Met	0	0	0				
Rate Met	90.91%	81.82%	81.82%				

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCHP's quality assessment and performance improvement program. This percent is calculated for the regulations that are applicable to the MO HealthNet Managed Care Program. 0 = Not Met; 1= Partially Met; 2 = Met
Sources: BHC, Inc., 2016 External Quality Review Monitoring MCHPs Protocols.

During the on-site reviews, it was evident to the reviewers that practice guidelines have become a normal part of each MCHP's daily operation. Practice guidelines are in place and the MCHPs are monitoring providers to ensure their utilization. All MCHPs met all the requirements for adopting, disseminating, and applying practice guidelines.

All MCHPs (100.0%) used nationally accredited criteria for utilization management decisions [438.240(b)(3)]. The tools the MCHPs reported using included: the InterQual Clinical Decision Support Tool; LOCUS/CALOCUS (Level of Care Utilization System/Child and Adolescent Level of Care Utilization System) for utilization management decisions in the provision of behavioral health services; and the Milliman Care Guidelines. These sources provided evidence-based criteria and best practice guidelines for healthcare decision-making. The MCHP staff could articulate how they utilized these tools and apply them to member healthcare management issues.

GRIEVANCE SYSTEMS

Subpart F of the regulatory provisions for Medicaid managed care (Grievances and Appeals) sets forth 18 requirements for notice of action in specific language and format requirements for communication with members, providers, and subcontractors regarding grievance and appeal procedures, and timelines available to enrollees and providers. All three MCHPs were found 100% compliant with the Grievance Systems requirements. The EQRO validated these findings while onsite at Missouri Care and Home State Health by requesting a random pull of the Grievance and Appeals files of each MCHP, and analyzing the files' compliance with the Federal and State guidelines.

4.3 Conclusions

All regulations for all MCHPs were at least Partially Met. All MCHPs were 100% compliant with three of the compliance areas validated during this review year. For the sixth consecutive year, none of the MCHPs were 100% compliant with all requirements. No MCHP could demonstrate case management information that was fully compliant with the standards related to care coordination. Additionally, provider availability was an issue for all MCHPs as evidenced by the results of the MO HealthNet Website Accuracy Survey. (See http://dss.mo.gov/mhd/mc/pdf/health-plan-website-accuracy-new-patient-acceptance-rates-report.pdf.)

All sources of available documentation, interviews, and observations at the on-site review were used to develop the ratings for compliance. The EQRO comments were developed based on review of this documentation and interview responses. All the MCHPs made it clear that they used the results of the prior EQR to complete and guide required change. This was evident in

many of the areas that the EQRO noted improvement. The following summarizes the strengths in the areas of Access to Care, Quality of Care, and Timeliness of Care.

Quality of Care

The 13 regulations for Enrollee Rights and Protections were 100% "Met" by all MCHPs. Communicating Managed Care members' rights to respect, privacy, and treatment options, as well as communicating, orally and in writing, in their own language or with the provision of interpretive services is an area of strength for all MCHPs.

The 10 regulations for Structure and Operations Standards were 100% "Met" by all MCHPs. These included provider selection and network maintenance, subcontract relationships, and delegation. The MCHPs had active mechanisms for oversight of all subcontractors in place. This is the sixth consecutive year that all the MCHPs maintained a 100% rating in this set of regulations.

Access to Care

The overall rating for MCHP compliance with the 17 federal regulations concerning Access Standards during this year's review was consistent with the prior year's rating (72.55%). However, this is a decrease from the 2014 rate of 78.43%. Home State Health and Missouri Care improved their individual ratings in this area while Aetna Better Health received a much lower rating than the prior year. This remains one of the lowest rated areas of compliance.

For the 2016 review, there was one regulation rated as "Not Met" for all three MCHPs; and one additional regulation rated as "Not Met" for Missouri Care. This is consistent with 2015 and a decrease from the 2014 review, when none of the regulations were found to be "Not Met". Aetna Better Health was found to be 64.71% compliant, Home State was found to be 82.35% compliant, and Missouri Care was 70.59% compliant.

The EQRO observed that all the MCHPs had case management services in place. However, the case management records requested did not always contain information to substantiate onsite observations.

Each MCHP described measures that they used to identify and provide services to MO HealthNet Managed Care members who have special healthcare needs. All the MCHPs described efforts to participate in community events and forums to provide education to members regarding special programs available.

Timeliness of Care

Timeliness of care is an area of decline in compliance for all the MCHPs; and this is the second consecutive year when the overall compliance rating for Measurement and Improvement was 84.85% in this area. Nine of the eleven applicable regulations were rated as 100% "Met." None of the MCHPs met all the regulatory requirements. All the MCHPs adopted, disseminated, and applied practice guidelines to ensure sound and timely healthcare services for members. The MCHPs used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management. However, lower Performance Measure ratings contributed to this decline.

The MCHPs continue to use member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery. The Case Management departments reported integral working relationships with the Provider Services and Relations Departments of the MCHPs. However, this was not always evident in the documentation reviewed.

All the regulations for Grievance Systems were 100% "Met" for all the MCHPs. These regulations all pertained to the written policy and procedure of the MCHPs.

Recommendations

1. MCHPs should continue to submit all required policy and procedures in a timely manner.
2. All MCHPs need to examine their case management programs. Attention to the depth and quality of case management services should be a priority for every MCHP. Goals should be established for the number of members in case management and the outcomes of the delivery of case management services. Continued attention must be applied to ensure the EQRO receives documentation as requested to validate that these services are occurring.

3. Accuracy in submission of Case Management records continues adversely affecting the Compliance ratings awarded to each MCHP. The MCHPs must be sure that all information is submitted accurately for all data requests from the EQRO.
4. Concerns remain about locating and identifying members and engaging them in the case management process. Ensuring that MCHP members have access to case management services remains a concern.
5. The MCHPs must improve the accuracy of their websites regarding providers. Provider availability was a major factor in the decline of compliance rates.
6. MCHPs should comply with data requests as written. Performance Measure ratings suffered from the MCHPs' inability to supply the data as requested. The EQRO cannot validate the accuracy of the reported data if they are not provided with the necessary information for the EQRO to recalculate the rates reported.

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5.0 MO HealthNet MCHP CASE MANAGEMENT

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5.1 Case Management– Special Project

The EQRO conducted a special project to follow up on MCHP compliance with federal regulations regarding quality, timeliness, and access to health care services as it is related to the provision of case management services. The objective of this special project is to complete an in-depth review of Case Management by assessing the MCHPs' service delivery and record keeping. The EQRO also evaluated each MCHP's compliance with the federal regulations and Managed Care contract as it pertained to Case Management.

The focus of this review was:

- Assessing the MCHPs' attention and performance in providing case management to:
  a. Pregnant members (OB);
  b. Members with special health care needs, including all other types of case management (Other/SHCNs); and
  c. Children with elevated blood lead levels (Lead);
- Evaluating compliance with the Managed Care contract; and
- Exploring the effectiveness of case management activities provided by the MCHPs.

METHODOLOGY

The review included the following components:

- Review of each MCHP's case management policy and procedures;
- Case record reviews sampled from case listings from each MCHP; and
- On-site interviews with case management staff and MCHP administrative staff.

CASE RECORD REVIEWS

A listing of cases that were open and active during the fourth quarter of 2016 was obtained from each MCHP, organized by category (OB, Other/SHCNs, and Lead). A random sample of cases was identified from the listings provided for each category. Case records were requested and received from each MCHP. The records were reviewed by EQRO Consultant Lisa Heying, R.N, and EQRO Assistant Project Director, Mona Prater. A pre-approved case review template based on the Case Management requirements found in the October 1, 2012 Managed Care contract, as amended, was used to assess the quality of the medical case records received.

The following reflects the number of submitted case records that meet these criteria:

Aetna Better Health –

21 OB cases received

- All were open during the 4th quarter of 2016 and contained case management information.

20 Other/SHCN cases received

- All were open during the 4th quarter of 2016 and contained case management information.

20 Lead cases received

- All were open during the 4th quarter of 2016 and contained case management information.

Missouri Care –

20 OB cases received

- All were open during the 4th quarter of 2016 and contained case management information

20 Other/SHCN cases received.

- 14 records contained case management information.
  - Three records represented members that declined case management service.
  - Three records represented members that were never located by the health plan.

20 Lead cases received.

- 15 records contained case management information.
  - Three records represented members that declined services.
  - Two records represented members that were never located by the health plan

Home State Health –

20 OB cases received.

- 19 records contained case management information.
  - One record represented a member that was never located

20 Other/SHCN cases received.

- All were open during the 4th quarter of 2016 and contained case management information

20 Lead cases received.

- All were open during the 4th quarter of 2016 and contained case management information.

The percentages in this report are based on the number of cases that contained case management information.

In the EQRO Case Management data request, the MCHPs were asked to submit a listing of all cases open during the last quarter of 2016. According to the total number of open cases submitted, Aetna Better Health is providing case management to .03% of their population; Missouri Care is providing case management to .02% of their population; and Home State Health is providing case management to .08% of their population. The following are the number of open cases submitted by each MCHP by case type:

Table 22 – Case Management Numbers by Case Type/MCHP Enrollment.

MCHP	OB	Other/SHCN	Lead	Total	Enrollment[5]
Aetna Better Health	133	472	159	746	278,480
Missouri Care	83	84	38	250	122,683
Home State Health	476	356	101	833	106,435

Missouri Care listings contained fewer names than anticipated. For the 2015 review, Missouri Care only included cases from their system that were found on the monthly "special health care needs" report received from MO HealthNet for that category of case management. In the 2016 request and subsequent communication, it was stressed by the EQRO that all open cases were to be included on the case listing submitted. The number of open cases reported by Missouri Care was small for all case management types (See Table 22).

On-Site Interviews

The purpose of the on-site interviews was to:

- Evaluate the case managers' knowledge of the State of Missouri contractual requirements of their position;
- Determine the methods used by case managers to operationalize policy in their daily activities; and
- Validate that case management policies are reflected in the practice at each MCHP.

[5] MO Healthnet Managed Care Enrollment Report. State Fiscal Year 2017. December 2016.

During the case record review process, on-site review questions were developed by the EQRO related to the factors detailed above. On-site interviews were conducted at Missouri Care and Home State Health.

5.2 Findings

Case Record Review Results

There are nine categories for which each MCHP's Case Management program is evaluated. Some of these also include sub-categories, which are identified below. These contract categories include:

1. Introduction to Case Management
    a. Third Party Contacts (i.e. an approved family member)
2. Assessment
    a. Comprehensive
    b. Updates
3. Care Planning
    a. Member Input
    b. PCP Involvement
4. Referrals
5. Face-to-Face Contacts
6. Progress Notes
    a. Required Contacts with Members
7. PCP Involvement
    a. Updates
8. Care Coordination
    a. Offer of Behavioral Health Services
9. Closing Criteria
    a. Transition Planning

The review of case management records, and subsequent interviews with case managers from Missouri Care and Home State Health provided information on the state of case management at the MCHPs. The results of this review are included by case type.

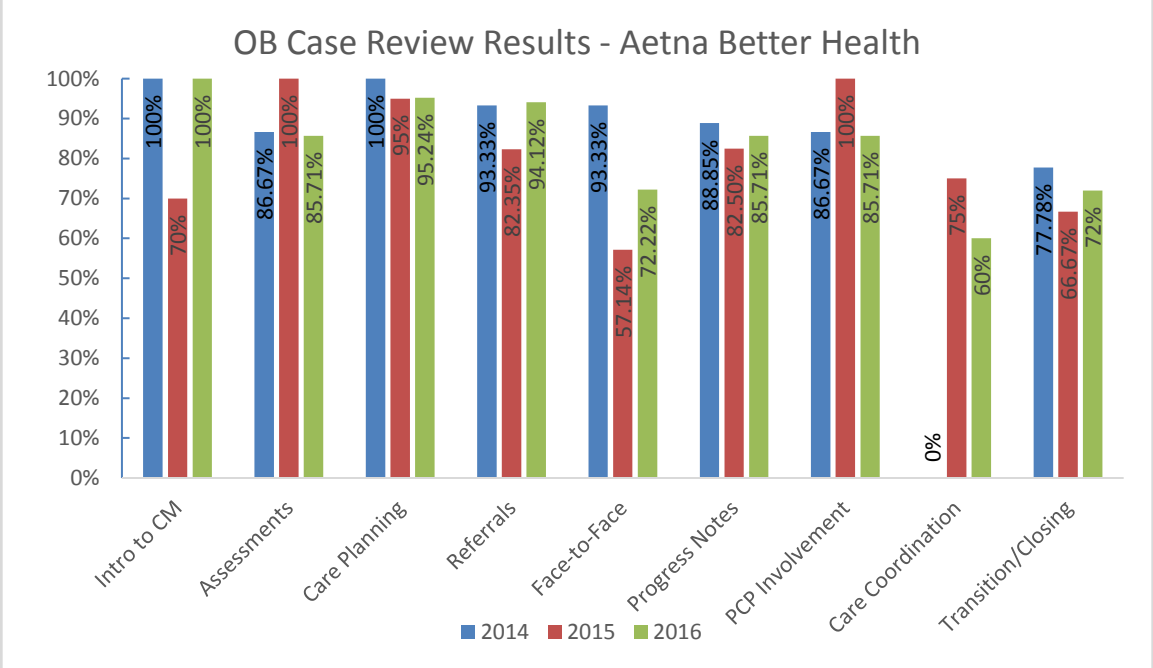
OB Case Review

Aetna Better Health

The case managers at Aetna Better Health made a strong effort to contact and introduce members to their case management program. Aetna Better Health reached pregnant members 100% of the time using a combination of in-home providers and drive-by services to locate members. Using these resources allowed Aetna Better Health to obtain current addresses and telephone numbers for members. Strengths were found throughout Aetna Better Health's OB case management program. Their records achieved a 90% or better rate in the following areas:

- Case planning
- Making appropriate referrals
- Producing complete progress notes

Figure 14 – OB Case Review Results Aetna Better Health.



Source: BHC, Inc., 2016 External Quality Review Case Management Review.

Although the overall percentage of completed assessments and PCP involvement were 85.71%, Aetna Better Health struggled with the sub-categories of:

- Ensuring that assessments were comprehensive (40%);
- Updating assessments that are over 6 months old (22.22%);

- Maintaining a relationship with PCP offices and informing them regarding care plans and care plan updates (76.19%); and
- Providing updates to PCPs (23.81%) for OB case management services.

Additional areas of the Aetna Better Health OB case review that indicated a need for improvement include:

- Providing Face-to-Face services (72.22%).
    - This was a 15% increase in CY 2015, but remains an area that requires attention.
- Care Coordination (60%).
    - This area needs attention, improved recording, and better discussions with members about how their needs were met in complex case management.
- Closing and Transitions at closing (72%).
    - Contacts with members diminished after the birth of the baby. Case notes reflected that fewer efforts to find members occurred after the baby's birth, as well.

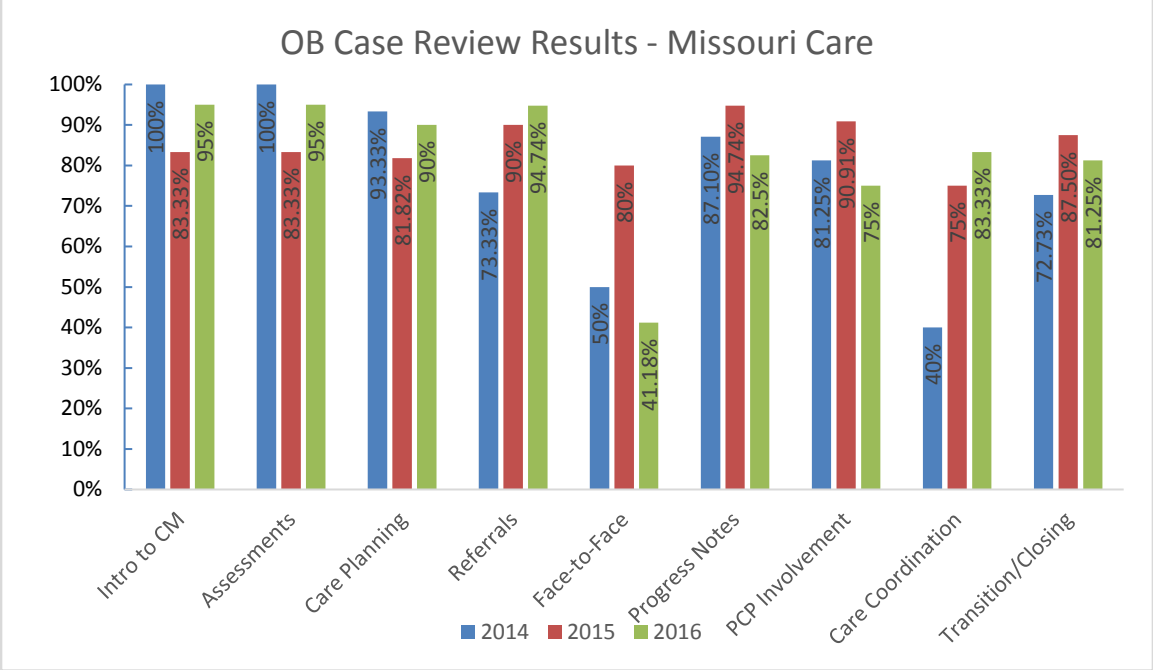
In prior years, Aetna Better Health provided a strong OB case management program. The EQRO observed that the attention to the case management program diminished, which is reflected in overall percentages.

Missouri Care

The EQRO observed that Missouri Care placed renewed efforts in their OB case management program. Introductions were enhanced using Missouri Care case managers, who made home visits in the Eastern MO HealthNet Region. Missouri Care excelled in the following areas during this review and were rated over 90% in:

- Introduction to Case Management
- Assessments
- Care Planning
- Making appropriate referrals
- Making required contacts with members

Figure 15 – OB Case Review Results Missouri Care.



Source: BHC, Inc., 2016 External Quality Review Case Management Review.

Areas that require improvement include:

- Approving Face-to-Face contacts (41.18%);
- Completing and recording progress notes every thirty (30) days (76%); and
- Updating PCPs periodically, or when a member's situation changes (58.82%).

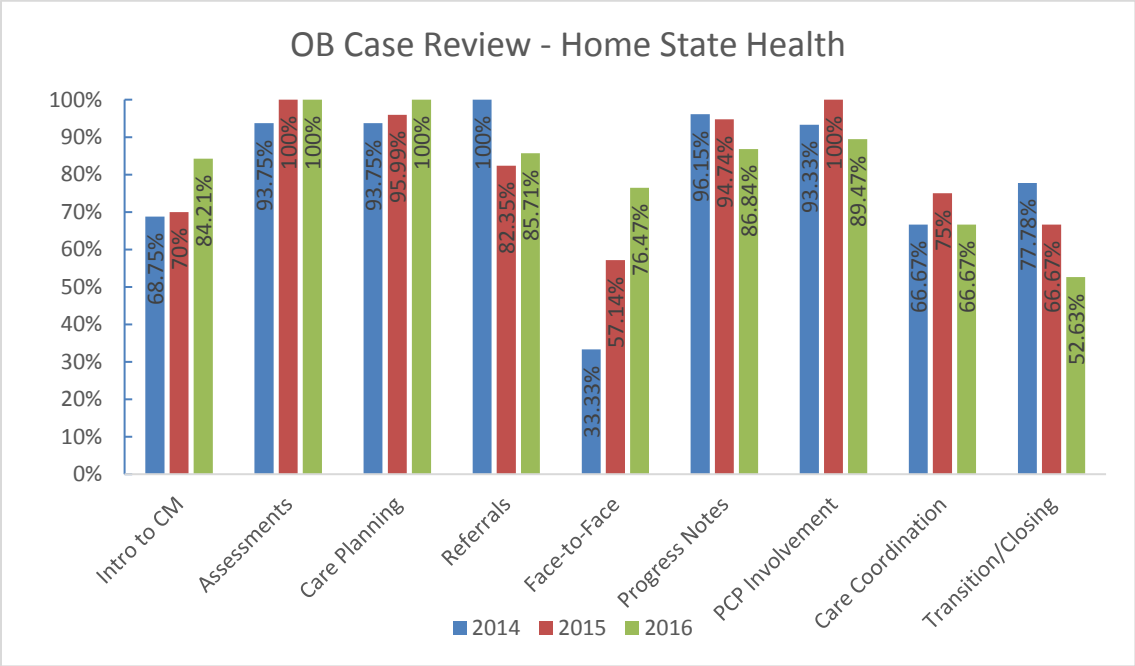
Missouri Care improved their approach to OB case management during CY 2016. Although there are areas that require improvement, Missouri Care case managers report a strong understanding of the requirements of the case management program. The EQRO found that they have not always provided detailed case notes reflecting the details of their work.

Home State Health

Home State Health enhanced their OB case management by developing an updated case management model. One case manager is now assigned to each member, which improves member access. During on-site interviews, case management staff related that this new method has improved their ability to engage and maintain contact with their members. These assertions are validated by the improvements that Home State Health made in the following areas of OB case management:

- Contacting members and introducing them to case management;
- Assessments were found in all OB case records reviewed (100%);
- Case plans were found in 100% of the OB cases reviewed;
- Approving face-to-face contacts when in-home services are required (76.47%);
- Making appropriate community and medical referrals (85.71%);
- Including progress notes monthly as required (89.47%)
- Making the required number of member contacts (84.21%); and
- Informing the PCP of their involvement in the family (89.47%).

Figure 16 – OB Case Review Results Home State Health.



Source: BHC, Inc., 2016 External Quality Review Case Management Review.

Home State Health continued to struggle in several of the sub-categories, including:

- Updating assessments every six months as required (0.0%);
- Updating Care Plans and contacting PCPs as required, when new care plans are developed (54.55%);
- Providing care coordination in complex OB cases (66.67%); and
- Closing and Transitions at closing (52.63%).
    - Contacts with members diminished as cases reached termination particularly after the birth of the baby, and fewer efforts were made to find members at the time of case closing.

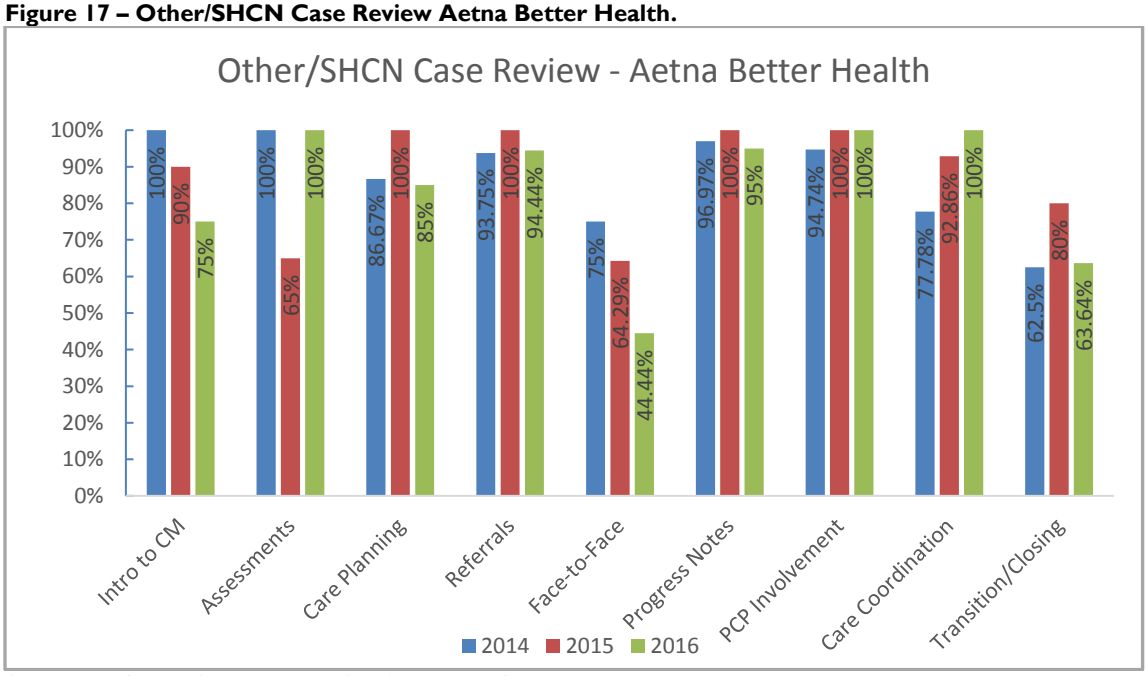
Home State Health case managers asked all pregnant members if they wished to have in-home services. When members accepted this service, notes and reports from the in-home providers were located within case notes. Case managers did not relate all members' responses or acceptance/rejection of in-home services. While cases were active, members received required services, referrals, and support in meeting their healthcare needs. An area where Home State Health case management requires improvement is maintaining contacts with members toward the end of their pregnancy, or after the baby is born. The EQRO observed that many cases are closed after sixty days; but few contacts are made.

OTHER/SHCNS CASE REVIEW

Aetna Better Health

Aetna Better Health's previously observed success declined in the area of contacting members needing other case management services, including special health care. Case notes indicated that minimum efforts were made to engage these members. Two phone calls, followed by an "Unable to Contact" letter, were found; but no additional efforts to obtain contact information or to engage the family were evident.

Figure 17 – Other/SHCN Case Review Aetna Better Health.



Source: BHC, Inc., 2016 External Quality Review Case Management Review.

Aetna Better Health declined in six of the nine categories measured for case type other/special health care needs; in these cases, fewer referrals for in-home services for members were found.

In ten cases, members had serious health care needs and would have benefited from in-home services; but no referrals were made. Aetna Better Health decreased in making contact and establishing relationship with members who had other/special health care needs after a referral to case management. They also declined in establishing and maintaining a relationship with the members' PCPs. The EQRO finds that these are indicators that the case management program diminished, negatively impacting member services.

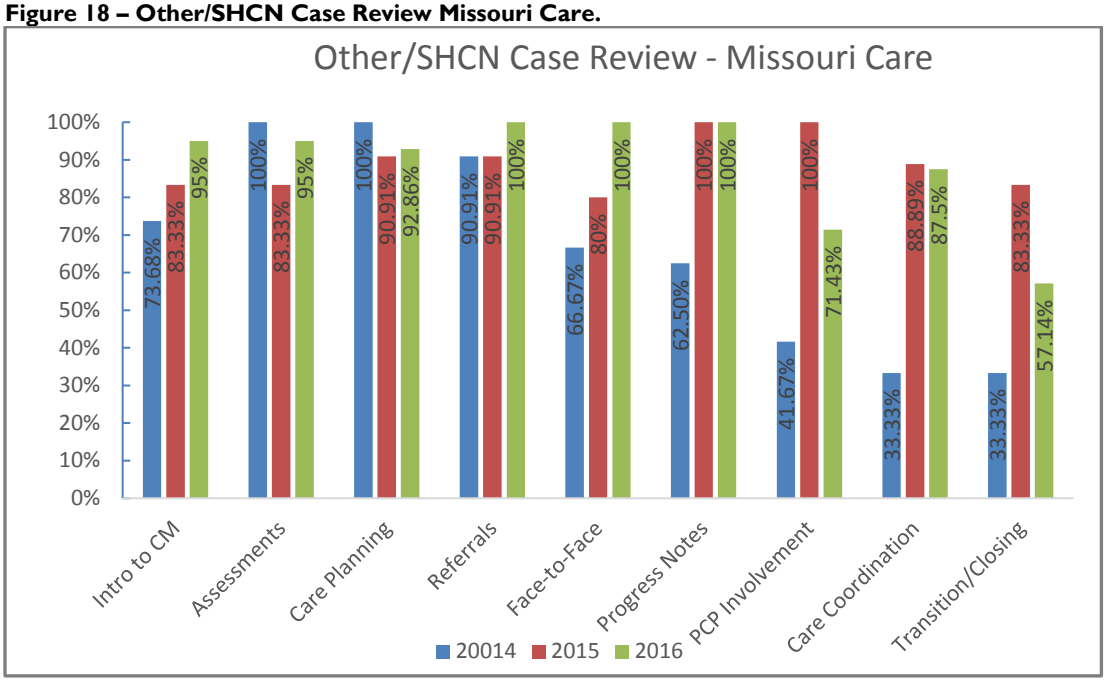
Missouri Care

Missouri Care made improvements in introducing and engaging members into the case management program when they were experiencing other/special health care needs (Other/SHCN). Although the Other/SHCN cases reviewed indicated three members refused services and three members were not located, Missouri Care case managers used in-home service providers, drive-by services, and contacts with PCPs to attempt to locate the members referred.

Case managers explained that, due to complex medical and social needs, these members often had multiple services in place including case management. These factors decreased the need for Missouri Care sponsored case management services. The case managers reported that it was their practice to maintain contact with the agencies directly involved with members. If any of these services ended, they stepped in and contacted members to ensure that necessary case management was in place. Missouri Care improved or remained consistent (100%) in seven (7) of the categories measured.

Missouri Care members with special health care needs were offered in-home services 100% of the time. Both referral forms and notes from the in-home service provider were found. Face-to-face services were made by Missouri Care case managers, as well as in-home providers. The EQRO found that this commitment to in-home services benefited members and enhanced the health care services received.

Figure 18 – Other/SHCN Case Review Missouri Care.



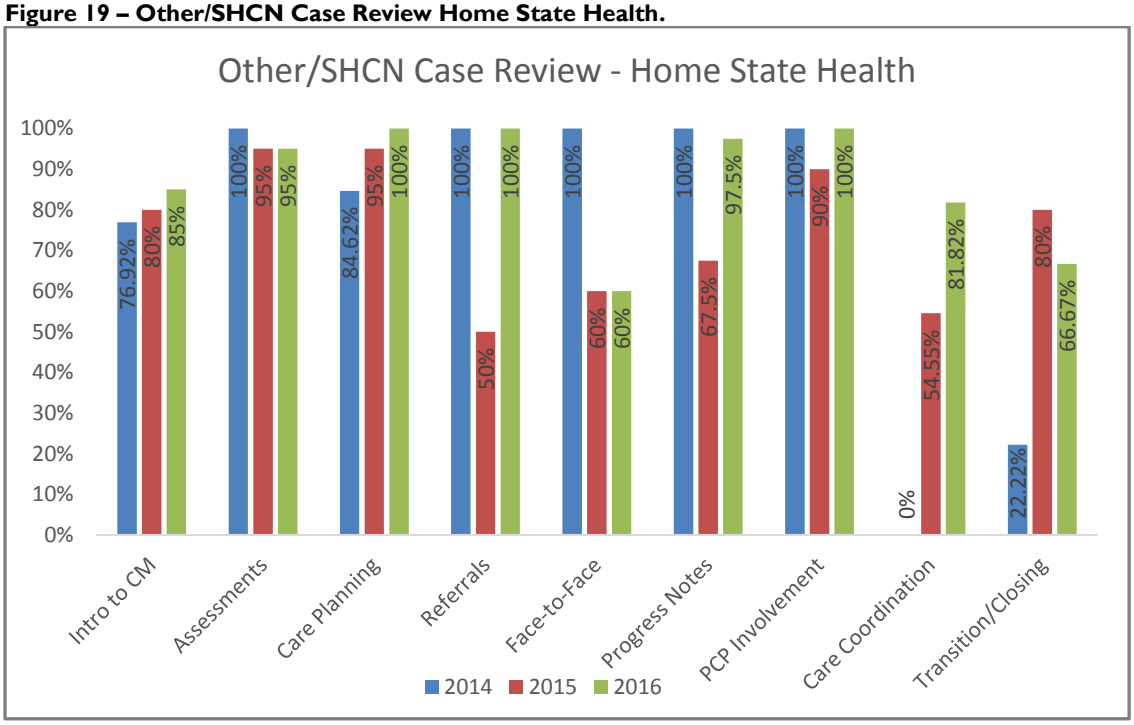
Source: BHC, Inc., 2016 External Quality Review Case Management Review.

Areas of concern included contacts with PCPs and Closing/Transition Planning. The case record information was sent electronically and the correspondence relevant to these cases was often not included. Correspondence often validates contacts and updates with PCPs. This information was not available; and if not present in progress notes, was considered not available. This may account for the decrease in this area. Providing case closing criteria and contact with members to develop transition planning also declined.

Home State Health

Home State Health has improved or maintained their performance in all areas of providing case management services to members with other/special health care needs. Although Home State Health case managers engaged and opened the cases that were referred 85% of the time, the case managers report that this is sometimes a challenging task. These members often have many social and medical service agencies involved. The case managers maintain contact with these members, and ensure that case management services are in place, whether this is from Home State Health, or another agency. The case managers report that they do open cases, but stay in the background until their direct services are needed to appropriately serve their members.

Figure 19 – Other/SHCN Case Review Home State Health.



Source: BHC, Inc., 2016 External Quality Review Case Management Review.

One area that continues to require attention is providing face-to-face services when necessary. The percentage of Home State Health Other/SHCN members receiving in-home services remained consistent with the previous year. In four cases evidence existed to make a referral for in-home services, but no referrals were found.

Lead Case Management

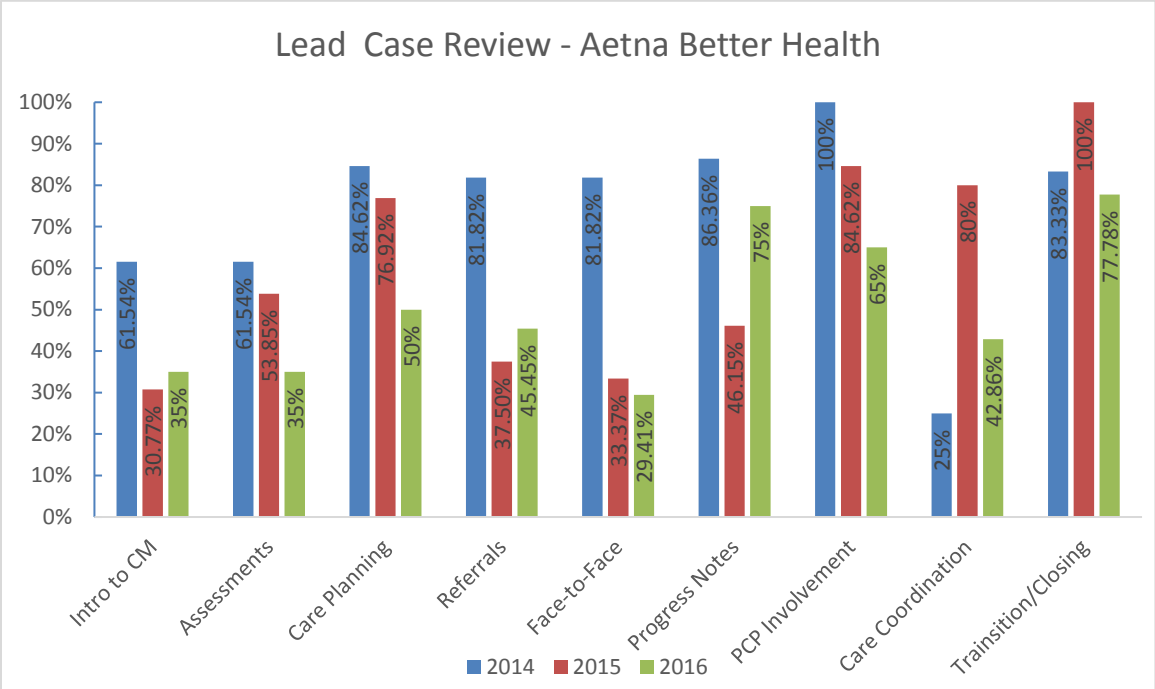
Aetna Better Health

Aetna Better Health is performing at less than 50% in six of the nine categories measured in the case management review. Additionally, in two of the three areas that measure above 50%, Aetna Better Health declined in the CY 2016 review. The need to enhance their lead case management program has been a recommendation of the EQRO for the past two years. This has not occurred and members with elevated blood lead levels (EBLL) have continued to suffer from this lack of attention.

Aetna Better Health failed to provide active case management in eight of the 20 lead cases reviewed (40%). The EQRO found that cases were opened in Aetna Better Health's system for these families. Case managers monitored the member's EBLL for the children involved. The case managers remained in contact with local health departments and the Department of Health

and Senior Services (DHSS) to obtain pertinent information on changes to the members blood lead level. No actual case management activities occurred. These cases did not contain notes at 30 day intervals as required.

Figure 20 – Lead Case Review Aetna Better Health.



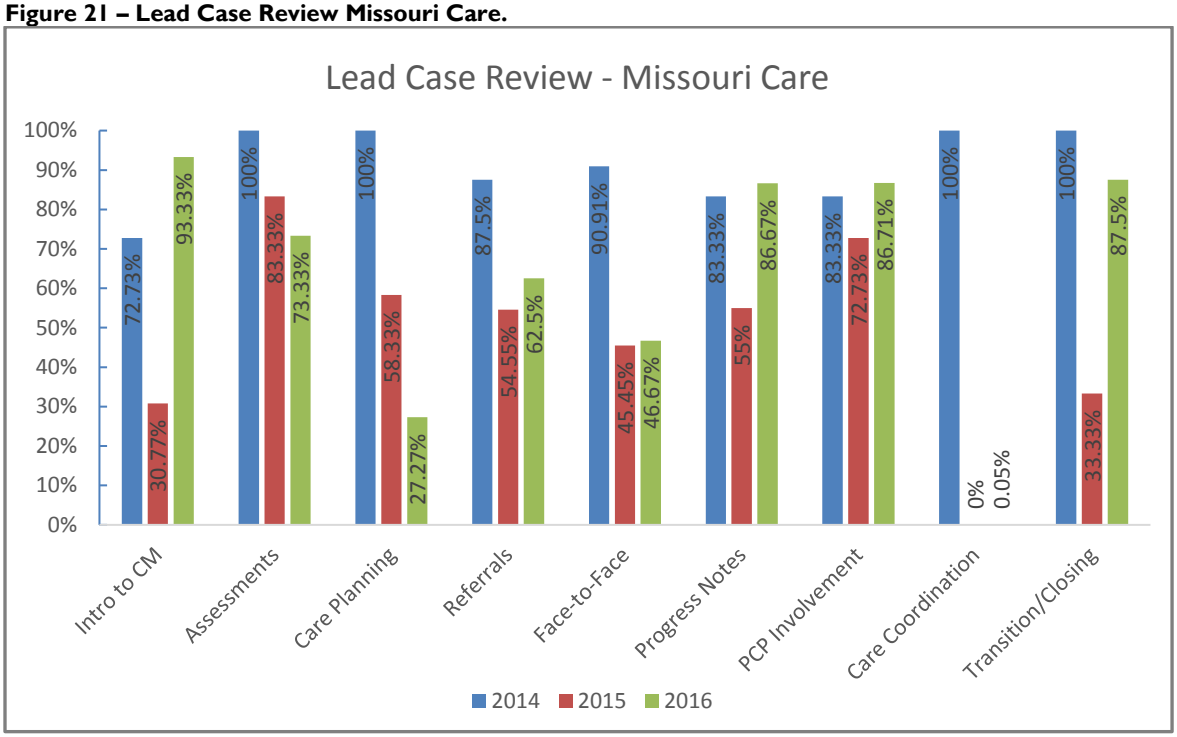
Source: BHC, Inc., 2016 External Quality Review Case Management Review.

Missouri Care

In the CY 2015 review, lead case management was identified as a problem for all three MCHPs. Missouri Care tried to improve services to their members by providing more active case management services. Missouri Care did not open five of the 20 cases reviewed. Missouri Care case managers did attempt to contact the member or their family. In three cases, the parent or guardian declined case management services. The case manager asked the family if it was acceptable to send educational information, and to call be-weekly to check on services needed, such as PCP appointments, or to learn if any other services were needed. In these cases, the families agreed, but the case records did not contain adequate information to complete an evaluation. In the remaining two cases, the case managers continued to monitor the members' blood lead level through local health departments and information from the Department of Health and Senior Services (DHSS). These cases contained periodic updates, but no regular contact with the member.

Missouri Care did make improvements in their lead case management program, although areas of concern continue. Care planning and care coordination are categories that need attention. Identifying cases that require care coordination created concern in 2015 and 2016. None of the cases reviewed were identified as needing this service regardless of the complexity of the situation presented. The EQRO is concerned that Lead cases are not given the same consideration as other case types. Face-to-face contacts are required in Lead cases, but were reported in less than 50% of the cases reviewed for the second year in a row.

Figure 21 – Lead Case Review Missouri Care.

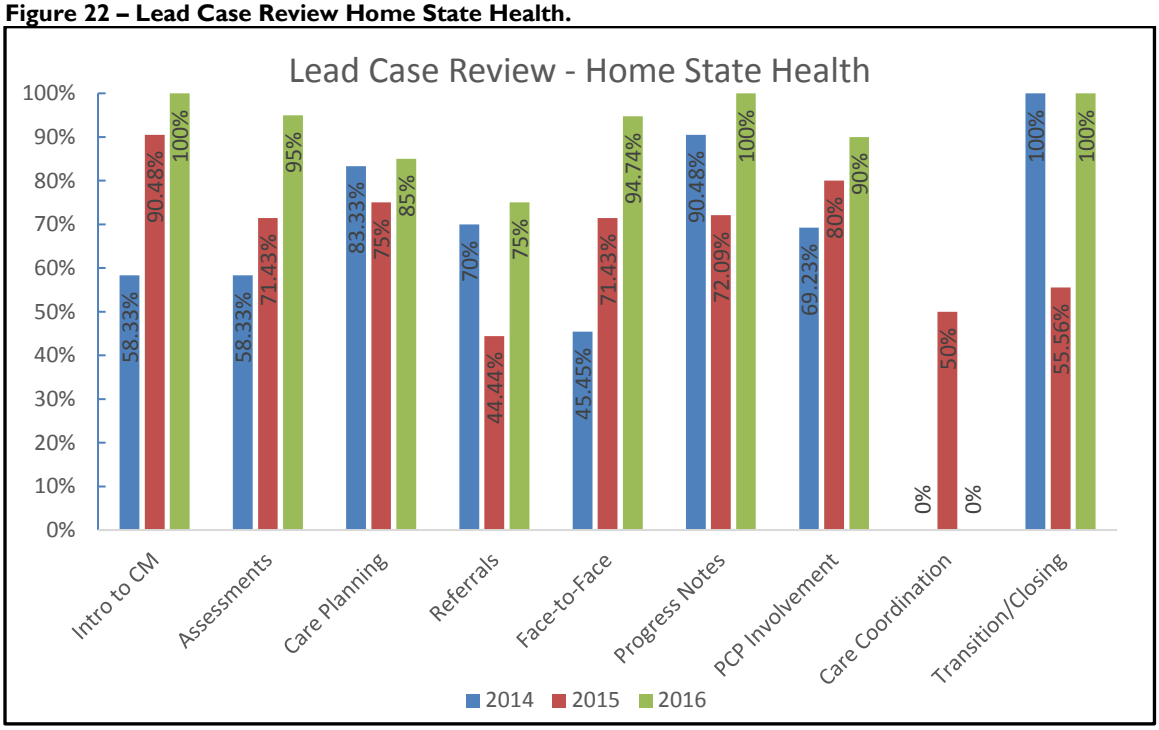


Source: BHC, Inc., 2016 External Quality Review Case Management Review.

Home State Health

In the CY 2016 review, Home State Health made significant improvement in the Lead case management program. The cases reviewed indicated improvements in eight of the nine categories evaluated. In care coordination, there were no cases that indicated a need for this level of service in CY 2014 or 2016. Home State Health made a commitment to find and engage all the members referred for Lead case management. Additionally, these members were referred to face-to-face visits; although in one record reviewed, it was not clear if these visits occurred. Home State Health's attention to the area of Lead case management was refreshing, as the EQRO has found that this service area has been neglected by all three MCHPs for several years.

Figure 22 – Lead Case Review Home State Health.



Source: BHC, Inc., 2016 External Quality Review Case Management Review.

OTHER OBSERVATIONS

In the sub-categories measured, there are areas that remained problematic for all MCHPs. These include:

- Third party contacts – The percentage of cases where permission to speak to a third party about the case was requested ranged from 71.47% (Missouri Care) to 52.46% (Aetna Better Health). These percentages reflect a lack of understanding on the part of case managers. The case managers interviewed expressed an understanding of the need to inform members of the MCHP's right to discuss issues with the PCP or specialist. However, the case managers did not indicate an understanding of the need to obtain the member's permission to speak to another family member or parent about healthcare issues.
- Updating Assessments – It is required to update assessments in any case that is open for more than six months.
    - Updated assessments were present in 85% of the Missouri Care cases reviewed;
    - Aetna Better Health records contained updated assessments in 39.02% of those reviewed; and

- Home State Health records contained updated assessments in 52.38% of the records reviewed.

- Updating PCPs – It is required to update PCPs in any case that is open for over six (6) months. Updates were found in Missouri Care records in 83.35% of the time; however, in both Aetna records (45%) and Home State Health records (29.41%), these updates did not occur regularly.
- Behavioral Health Services – It was found that during assessments members indicated a need for behavioral health services; and yet in many of these cases follow-up did not occur, or referrals were not recorded in case notes. If a referral is not made, this should be documented in the case notes. If a referral occurs, this should be included in the progress notes, as should any additional care coordination.

5.3 Observations for All MCHPs

Quality of Care

When members are properly introduced to and engaged in case management, the quality of service delivery improves. For example, case managers maintain contact with the members they serve throughout the case management process. Case record reviews and interviews substantiate that, in some cases, the case manager advocates for extraordinary services to meet a member's healthcare needs.

Aetna Better Health improved in two of the nine categories measured:

- Aetna Better Health has not created new or innovative approaches throughout their case management program. The declining numbers observed during 2016 indicate that requirements of the case management program, based on the MO HealthNet contract requirements and federal regulations, are not receiving the attention necessary to achieve improved results. The lack of improvement in the remaining seven standards indicates an absence of attention to these regulations. Serious deficiencies were observed within the case management program.

Missouri Care improved in five of the nine areas measured in this review:

- There is continued room for improvement in case management services. Missouri Care has initiated innovative interventions, such as doing in-home case management, which indicates a commitment to providing quality services to members. Missouri Care also

partners with the Children's Mercy Pediatric Care Network (PCN) in the Western Region. The PCN cases reviewed continue to exhibit a high standard of care.

Home State Health improved in eight of the nine areas measured:

- Home State Health remains committed to improving case management and developing quality case management services. They made a strong effort to locate and introduce members to the health plan and case management. They reached 100% of their lead cases to introduce and offer case management. These efforts allowed the Home State Health to improve the quality of care their members receive. Home State Health updated their case management model to assign only one case manager to a family or member. This step provides additional evidence that they are continuing to improve services.

Access to Care

Access to care was enhanced when case managers actively worked with families. Reviews indicated that the creative efforts used to locate members were enhanced by Missouri Care and Home State Health. These efforts resulted in more access to care by their members. All MCHPs continued to use contractors who "drive by" members' reported addresses to learn if they are living there and to obtain forwarding information whenever possible. Missouri Care began using case managers to provide in-home services. Case managers at all MCHPs need to contact a variety of sources to track members' whereabouts and make required contacts. Continued efforts are needed to partner with home health agencies to ensure that members follow through on their part of a care plan and obtain the services they need.

- Access is improved when case managers make an active effort to assist members in obtaining services, community, or provider based, which uniquely meet their needs. Case managers are knowledgeable about available resources. Attempts to connect members to these resources improved in 2016 for Missouri Care and Home State Health.
- Access improved when case managers remained in contact with members receiving OB services. This ensured members' access to services, such as a follow-up with their OB-GYN, and a first visit to the pediatrician for the baby.

- Case managers report losing contact with members who had newborns at the end of the case management process, so no transition plan was developed. This standard was improved for all three MCHPs; but the highest percentage received was 71.43%.
- Face-to-face contacts are not occurring as often as necessary, even when a contracted provider is authorized to see the member and report their contacts.
- Aetna Better Health and Home State Health improved in providing face-to-face services for OB cases. Whereas, Missouri Care declined in this area of case management.
- Missouri Care made referrals for Other/SHCN cases 100% of the time in the cases reviewed. Whereas, Aetna Better Health declined in face-to-face services for Other/SHCN cases and Home State Health remained consistent.
- A specific area of concern in 2015 for all MCHPs was Lead cases where in-home services are required. Aetna Better Health and Home State Health improved in providing face-to-face contacts for lead cases in 2016. Missouri Care remained relatively stable.

TIMELINESS OF CARE

When case managers are actively serving a member, fewer emergency department visits occur, members attend scheduled appointments, and assistance is provided to ensure that members see specialists in a timely fashion.

- In the OB cases reviewed where there was evidence of active case management, follow-up visits with the OB, and initial pediatrician appointments for the newborn occurred within specified time frames. Parents who received these services often enrolled their babies with the MCHP and ongoing preventive care was initiated. Home State Health improved in this area, while Missouri Care and Aetna Better Health maintained contact in OB cases over 90% of the time.

- Case managers continue to report that they have difficulty creating a useful transition plan with the member when it appears the case should be closed. However, transition planning prior to case closing improved for all three MCHPs. In cases where transition planning occurred, case managers were diligent in maintaining contact with members and discussing aftercare with them.
    - In past reviews, it appeared that after members' health care needs are met, the member lost interest in case management and no longer returned calls or

responded to letters requesting that they contact the case manager. This remains an issue. The case managers interviewed during the on-site review find this troubling and continue their efforts to maintain a relationship with members while closing their case. When contact through closing and development of a transition plan occur, case managers report that members often contact them afterward to seek assistance with short term problems.

- Information sharing with PCP offices and sending a letter at case closing continues to require attention. Home State Health did improve in this area while Missouri Care and Aetna Better Health rates declined.

RECOMMENDATIONS

1. When case listings are requested, three categories are defined. Two of these lists include all OB case records and Lead case records. The third category is entitled "Other/Special Health Care Needs" (Other/SHCNs) to comply with the language in the federal protocol. This includes all other types of case management cases open in the MCHP system. A comprehensive listing of open and active cases for all case management activities must be submitted. If there is a question about the cases to be included in listings, the MCHPs should contact the EQRO for clarification.

2. In the 2016 review, Missouri Care and Home State Health sent case records electronically. MCHPs must ensure all information is available electronically; and the EQRO has access to case records throughout the review process.

3. The case notes should include information indicating an understanding of the information collected through the assessment process or tool. An explanation of how the assessment drives the services provided to the member must be contained in case notes. If a problem is reported during the assessment, such as a need for behavioral health services, it should be addressed; and any activities should be recorded in the case notes. If there is a reason that a problem is identified or a service is not provided, this information should be recorded. If an initial intake indicates that a member has "high" needs, and the complete assessment finds this is not accurate, this should be explained in the case record.

4. All MCHPs should invest in a case management model that ensures members receive the face-to-face contacts required. This may require more direct contact with members and better progress notes when a contracted entity is used. When a case is complex and the member would benefit from face-to-face visits, this should be recognized and noted by the case manager. If there is a reason that these visits are not authorized, this should be recorded in the case notes.

5. Continued efforts to improve lead case management must include active attempts to contact the member or member's family, in which a relationship should be established. Opening a case in the system and checking on the member's progress with the local health department or the PCP offices does not constitute case management services. Case openings should occur in every lead case, and case notes should detail case management efforts to locate and contact members throughout the time the case is open.

6. Minimum required efforts to locate members are defined by the MO HealthNet contract. The rigorous efforts to locate members observed in some cases should be expanded to all case types.

7. Renewed attention to the lead case management program is required. Many of these cases include multiple children and often include additional medical issues. Complicating families' situations by failing to coordinate case assignments or contacts can lead to a lack of cooperation and confusion, often perceived as a negative response from the member or family. Case managers report that they usually carry the entire family and all service needs. This information is not reflected in the case notes. Some reference to working with the entire family should be in progress notes.

8. Complex case management, and care coordination are not consistently defined and implemented at each MCHP. The MCHPs do not have to operate in the same manner, but how these services are included should be defined and implemented consistently.

9. The number of cases opened for case management remains a concern. Locating and identifying the members referred, and engaging them in the case management process

are critical to meeting members' healthcare needs. The MCHPs are not providing case management to even 1% of their population. Although there is no requirement that each MCHP have a minimum number of members in case management, ensuring that members receive this care should be a priority.

10. Continued efforts should be made to ensure that case managers contact the PCP, and keep them informed regarding case updates and changes.

11. Case managers should assist members directly with problems like identifying a PCP or specialist. Although the goal of case management is to nurture independence, the case manager should not expect the member to "call Member Services and get a list" when they need a PCP, dentist, or behavioral health provider.

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6.0 Aetna Better Health of Missouri

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6.1 Performance Improvement Projects

Methods

Document Review

Aetna Better Health of Missouri (Aetna Better Health) supplied the following documentation for review:

- Improving Childhood Immunizations; and
- Improving Oral Health.

PIP Submissions

PIP submissions were requested of the MCHP by the EQRO in February 2017. PIPs containing all information available were received in March 2017. The evaluation of Aetna Better Health PIPs is based on the information submitted at that time. Due to expiration of Aetna Better Health's contract with MO HealthNet, no on-site interviews were conducted regarding the Aetna Better Health PIPs.

The PIPs submitted for validation included a substantive amount of information. The MCHP submitted information including all development and planning for the clinical PIP. This is a new study topic and interventions were implemented in 2016. Baseline information from HEDIS 2016 was included as was unaudited administrative data from HEDIS 2017. The rates submitted did not include hybrid and audited data.

The HEDIS 2016 outcome data and unaudited HEDIS 2017 data were submitted for the non-clinical PIP. Due to the expiration of Aetna Better Health's contract, it was not possible to obtain the finalized HEDIS 2017 data.

Findings

Clinical PIP – Improving Childhood Immunizations

Aetna Better Health's clinical PIP was developed to improve the rate of childhood immunizations for MCHP members up to 2 years of age. The MCHP recognized a problem with the number of children who were receiving the correct vaccinations during early childhood. The MCHP cited vaccinations as a primary method to provide preventive healthcare, thereby preventing illness for their members. Additionally, the MCHP cited research concluded that an increase in the number of children who are vaccinated provides a layer of protection to the

community. When most of the members of a community are immunized against a contagious disease, there is little opportunity for an outbreak of that disease.

This PIP contained interventions that address the need to increase the number of children who obtain a complete set of required vaccinations. The goal of this PIP is to increase the compliance rate of each of the sub-measures within the Combo 3 vaccinations to 90% by the second year of the PIP. The data analysis provided compliance rates for all 14 vaccinations included in Combo 10, and used data related to Combo 3 of the HEDIS measure.

Focusing MCHP resources on increasing the number of children receiving all necessary immunizations will improve their goal of increasing preventive services. The baseline year for this PIP is the calendar year (CY) 2015. Interventions began in January 2016; and these interventions addressed the following barriers:

Member Barriers:

- Parents or caregivers do not support immunizations.
- Parents are unaware of the need to schedule immunizations for their children.
- Some parents are unable to get to a doctor's office or health department during routine hours.
- Some parents lack knowledge of the need for immunizations and the time to schedule immunizations.
- Parents fear that vaccinations cause Autism or Mercury Poisoning.

Provider Barriers:

- PCPs do not provide immunizations or have vaccines available, causing the member to find another site and a second visit to obtain them
- Provider offices do not remind patients or schedule routine visits in the future.

Plan Barriers:

- Aetna Better Health is not informed if a member obtains immunizations through their local health department. Local health departments do not necessarily bill for immunizations; and these actions are not captured in HEDIS administrative data. Aetna Better Health also performs a hybrid review; but unreported health department activities

are not available for a record pull. Some Health Departments are not aware of the importance of the HEDIS reporting process.

- The MCHP does not have access to the DHSS immunization registry. DHSS does not directly share registry data with the MCHPs. Aetna Better Health has experienced a data flow problem from the DHSS database to the MCHP database. During 2016, a quarterly submission of this information generated by MO HealthNet began, which may improve data sharing in the future.
- Aetna Better Health lacks a consistent process to ensure that files received are entered into their HEDIS system.
- Aetna Better Health reports that they have received inconsistent data regarding which children received immunizations.

The MCHP established their baseline using HEDIS 2016 rates. The MCHP's Quality Improvement team met to establish more material interventions and to assess all potential barriers for use in future years. Full implementation of this PIP began in January 2016. Aetna Better Health recognized that the problems outlined in their Study Topic continue to exist, and used this PIP to remediate the issues addressed.

The following Validation Worksheet provides the details of how the project meets each PIP requirement:

Demographic Information		
Plan Name or ID: Aetna Better Health of Missouri		
Name of PIP: Improving Childhood Immunizations		
Dates in Study Period: January 1, 2016 to present		
I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
Step 1: REVIEW THE SELECTED STUDY TOPIC(S)		
Component/Standard	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	X Met __ Partially Met __ Not Met __ Unable to Determine	The study topic presentation is well developed and informative. It provides convincing evidence that this is a viable, important topic to address as a performance improvement project. The literature review and research are in-depth.
Clinical _xx_ Prevention of an acute or chronic condition ___High volume services ___Care for an acute or chronic condition ___High risk conditions		
Non-Clinical ___Process of accessing or delivering care		
1.2 Did the Plan's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	X Met __Partially Met __Not Met __Unable to Determine	The goal of this PIP is to increase the number of members/children who complete their Combo 3 immunizations. They provide information to clearly addresses the fact that this is a key aspect of enrollee care.
Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.		
1.3 Did the Plan's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	X Met __Partially Met __Not Met __Unable to Determine	The members who are the focus of this study include all members up to 2 years of age. They will review all available data bases to identify members who are non-compliant, enrolled for over 90 days, and who are within the age range defined for the study.
Demographics: _xx_ Age Range _____Race _____Gender Medical Population: __xx__ Medicaid Only _____ Commercial	Totals	_3_ Met _____Partially Met _____Not Met _____UTD

Step 2: REVIEW THE STUDY QUESTION(S)		
2.1 Was the study question(s) stated clearly in writing?	**X** Met __Partially Met __Not Met __Unable to Determine	The study question is understandable. The narrative states that the goal is to increase the compliance rate to 90% for Combo 3. This goal and the study population are stated in the study question.
Include study question(s) as stated in narrative: Will implementation of specific interventions increase the HEDIS rate of children from 6 weeks of life to 2 years of age who receive immunizations by two years of age, toward the goal of 90%?	Total	**1** Met ___Partially Met _____Not Met _____UTD
Step 3: Review Selected Indicators		
3.1 Did the study use objective, clearly defined, measurable indicators?	**X** Met __Partially Met __Not Met __Unable to Determine	The discussion defines the numerator and denominator that will be used to measure the PIP outcomes. The discussion refers to Table 3, which provides the ICD codes to be used in this measure. How this information will be used making it pertinent to this study is explained.
List Indicators:		
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	**X** Met ___Partially Met __ Not Met __ Unable to Determine	The indicators imply that this is a measurement of changes in health status strongly associated with improved outcomes. The HEDIS data, both administrative and hybrid, will be used to measure the outcome of the interventions implemented, which started in January 2016.
Are long-term outcomes implied or stated: xx yes __no xx Health Status _____Functional Status _____Member Satisfaction _____Provider Satisfaction	Totals	**2** Met ___Partially Met _____Not Met _____UTD
Component/Standard	**Score**	**Comments**

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did the Plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	**X** Met __ Partially Met __ Not Met __ Unable to Determine	The MCHP will review their internal database to identify members who are non-compliant with obtaining the Combo 3 immunizations. These members will be targeted for outreach interventions. The study population includes all members who are under 2 years of age. It also includes all members who are enrolled with Aetna for 90 consecutive days.
Demographics _xx_ Age Range _____Gender _____Race Medical Population: _xx__Medicaid Only _____Commercial		
4.2 If the studied included the entire population, did its data collection approach capture all enrollees to whom the study question applied?	**X** Met __Partially Met __Not Met __Unable to Determine	The data collection approach is focused on identifying all members who meet the criteria for this study. In table 2 of the PIP submission, the immunization group indicates the study refers to Combo 3.
Methods of identifying participants: _____Utilization data _____Referral _____Self-identification _____Other _____	Totals	**2** Met ____Partially Met _____Not Met _____UTD
Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	__Met __Partially Met __Not Met __Unable to Determine	This study will not use sampling methods.
Previous findings from any other source: ___literature review ___baseline assessment of indices ___other		
5.2 Were valid sampling techniques that protected against bias employed?	__Met __Partially Met __Not Met __Unable to Determine	
Specify the type of sampling or census used:		
5.3 Did the sample contain a sufficient number of enrollees?	__Met __Partially Met __Not Met __Unable to Determine	
_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	Totals	_NA_Met ____Partially Met ____Not Met _____UTD

Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	X Met __Partially Met __Not Met __Unable to Determine	The study design described data to be collected specific to this study. As stated earlier, Table 4 includes the immunizations included in Combo 10 and 3. An explanation of this table is provided.
6.2 Did the study design clearly specify the sources of data?	X Met __Partially Met __Not Met __Unable to Determine	This section identifies the population, and explains that the baseline information (CY 2015) will include all members within a specific age range, and will not apply the "allowable gap" criteria used in the HEDIS measure. All members who meet the age criteria will be included in the interventions.
Sources of data: ___Member _xx_ Claims ___Provider _____ Other:		
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	X Met __Partially Met __Not Met __Unable to Determine	The systems and methods for extracting valid and reliable data are described in detail. Individuals involvement and their expertise are included.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	X Met __Partially Met __Not Met __Unable to Determine	
Instruments used: _____Survey _____Medical Record Abstraction Tool Other: _____		
6.5 Did the study design prospectively specify a data analysis plan?	X Met __Partially Met __Not Met __Unable to Determine	The instruments used and how the data are accessed is detailed in the narrative. The information provided leads to confidence that consistent and accurate data will be collected and reported.
6.6 Were qualified staff and personnel used to collect the data?	X Met __Partially Met __Not Met __Unable to Determine	The data analysis plan is presented. It is clear and understandable. Audited HEDIS rates will be used to report outcome data.

Project Leader Name: Dale Pfaff Title: QM Nurse Consultant Role: Responsible for all aspects of the PIP. Other team members: Names/Roles: Carol Stephens-Jay – data analysis Beginning 03/2017 Project Lead became Sue Holmes. Dr. Angela Miller is the medical director involved.	Totals	**6** Met _____Partially Met _____Not Met _____UTD
Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**X** Met __Partially Met __Not Met __Unable to Determine	The MCHP began interventions January 2016. They have a balance of interventions between members, providers, and themselves. They are continuing to assess the problem and develop best methods to impact it. The MCHP wants to effectively encourage parents to obtain immunizations as efficiently as possible.
Describe Intervention(s): **Member**: 1) Use the current missed appointment reminder and birthday card system to notify parents of the need for immunizations. 2) Use text messaging for qualifying families and mailers to remind care givers that immunizations are needed. 3) Inform parents of transportation available. 4) Provide children with a growth chart through provider offices and health fairs. 5) Create Immunization Fact mailer to parents of newborns at each child's 1st birthday. **Providers**: 1) Target Head Start - for possible intervention opportunities. 2) Review provider care gaps and identify them in reports to providers. Encourage them to use as a tool to identify patients needing services. Contact regarding outcomes. **Plan**: 1) Identify non-compliant members in top 10 counties in each region and make a targeted call to inform members of the need of immunizations. 2) the MPHC Lead Data Analyst is responsible for developing a relationship w/ State contact person to obtain registry information quarterly. 3) Migration to Aetna Processes. 4) Collaborate with MO Health Plus to obtain more accurate and timely data regarding children receiving immunizations.	Totals	**1** Met _____Partially Met _____Not Met _____UTD
Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The data analysis was performed as described in the data analysis plan. It is limited as the only HEDIS data available was for CY 2015/HY 2016, which is the baseline year. They did include administrative data, which is unaudited and does not include Hybrid information. These data are not available until June 2017, and the MCHP will be closed prior to this date.

This Element is "Not Met" if study is complete and there is no indication of a data analysis plan (see step 6.5)		
8.2 Were the PIP results and findings presented accurately and clearly?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The PIP results that were available are presented in a clear understandable manner. The Tables and figures that could be included were labeled accurately and presented a clear picture of where the MCHP stands in relation to meeting immunization goals.
Are tables and figures labeled? xx yes __no Are they labeled clearly & accurately? xx yes ___no		
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The data that were submitted (through March 2017) included the initial and repeat measurements that were available. No final HY 2017 data is available.
Indicate the time periods of measurements: HY 2016 Indicate statistical analysis used: n/a Indicate statistical significance level or confidence level if available/known: _____99% ___95% ___Unable to determine		Statistical analysis and factors that threaten validity are not yet available.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and any follow-up activities?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	
Limitations described: _____ Conclusions regarding the success of the interpretation: _____ Recommendations for follow-up: _____	Totals	**3** Met _____Partially Met _____Not Met **1** Not Applicable _____UTD
Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The methodology used in HY 2016 would be repeated for HY2017; but this complete data is not yet available.

Ask: Were the same sources of data used? Did the use the same method of data collection? Were the same participants examined? Did they utilize the same measurement tools?		
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	__Met __Partially Met __Not Met __X__ Not Applicable __Unable to Determine	
Was there: _____ Increase _____Decrease Statistical significance ___yes ___no Clinical significance ___yes ___no		
9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	__Met __Partially Met __Not Met __X__ Not Applicable __Unable to Determine	
Degree to which the intervention was the reason for change ___No relevance ___Small ___ Fair ___High		
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	__Met __Partially Met __Not Met __X__ Not Applicable __Unable to Determine	
_____Weak _____Moderate _____Strong	Totals	__1__ Met _____Partially Met _____Not Met 3_ Not Applicable _____UTD
Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	__ Met __ Partially Met ___Not Met __X__ Not Applicable __ Unable to Determine	
	Total	___Met _____Partially Met _____Not Met

		_1_ Not Applicable _____UTD
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	Comments
Were the initial study findings verified upon repeat measurement?		

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.

Conclusions: This continues to be a framework for an effective PIP. This PIP has the potential to meet the goals of the MCHP. Good analysis of information currently available. The baseline year was presented, and it appeared that reaching the 90% mark would be achievable.

Recommendations: Continue the development of baseline data, and implementation of the interventions identified. Continue to explore innovative interventions not used and reused that have lacked the desired impact.

Check one:

☐ High confidence in reported Plan PIP results
☐ Confidence in reported Plan PIP results
☐ Low confidence in reported Plan PIP results
☐ Reported Plan PIP results not credible
X Unable to determine – the PIP is new and has produced no results

NON-CLINICAL PIP – IMPROVING ORAL HEALTH

Aetna Better Health's non-clinical PIP, based on the statewide PIP project, included information that addressed the MCHP's population individually.

The following interventions were added to their project for CY 2016:

- Building a relationship with one large FQHC, Affinia Healthcare, as a best practice model. Aetna Better Health independently and in collaboration with the Dental Task Force, began conversations with Affinia Healthcare in St. Louis, MO. This FQHC has a new dental facility with 92 dental chairs and is staffed by full-time workers and students from A.T. Still University's Missouri school of Dentistry and Oral health.
- In June 2016, Aetna Better Health began sending a report to Affinia of their members who were non-compliant in obtaining their annual dental visit for at least six (6) months. The first report sent to Affinia contained 2,500 non-compliant members. Affinia made appointments with 500 of their patients (MCHP members) using that report. Subsequent reports were submitted to Affinia monthly for the remainder of 2016.

Aetna Better Health's change in the Annual Dent Visit HEDIS rate results from HY 2016 to HY 2017 are as follows:

- Eastern Region – Decreased by .78%;
- Central region – Increased by 1.20%;
- Western region – Decreased by 1.20%; and
- Statewide aggregate – Decreased by .58%.

At the end of the first quarter of 2016, Aetna Better Health recognized irregularities in provider reports between the MCHP and their dental subcontractor, DentaQuest. They learned that the Aetna Better Health software was not counting dental services provided by dentists listed as "general practitioners" and was counting member interactions with these providers as medical rather than dental visits. This problem was corrected in June 2016. Improvements were identified beginning in August 2016. The data indicated that this change, and the addition of the Affinia project, impacted the data for the Eastern Missouri MO HealthNet region beginning in August 2016, due to the two-month lag in receipt of claims data.

The MCHP did not meet their HEDIS year goal of a 3% improvement for 2016. This is the second year that the MCHP has failed to meet the 3% annual improvement goal. Data was presented about the outcomes of this PIP, which included increases through CY 2014. The MCHP provided a discussion about the data and how the figures are analyzed in their PIP submission. Due to the stagnant growth toward goal attainment in the past two years, the Project Lead presented significant changes to MCHP interventions for this project. However, due to the expiration of Aetna Better Health's contract with MO HealthNet, this PIP has been discontinued.

The following Validation Worksheet provides the details of how the project meets each PIP requirement:

Demographic Information		
Plan Name or ID: Aetna Better Health of Missouri		
Name of PIP: Improving Oral Health		
Dates in Study Period: 2008 - 2016		
I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
Step 1: REVIEW THE SELECTED STUDY TOPIC(S)		
Component/Standard	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	**X** Met __ Partially Met __ Not Met __ Unable to Determine	While this is a statewide PIP, the MCHP personalized their approach to designing a project to improve members' oral health by obtaining annual dental visits. The study topic discussion was complete and focused on the needs and circumstances of Aetna Better Health members. This was an excellent example of taking a statewide topic and creating applicability to Aetna Better Health members. Regional and national information was utilized from the literature review presented. This information presented evidence validating the need to improve the number of members/children receiving annual dental visits. The narrative presented convincing evidence that this is an important area of concern.
Clinical ___Prevention of an acute or chronic condition ___High volume services ___Care for an acute or chronic condition ___High risk conditions		
Non-Clinical xx Process of accessing or delivering care		
1.2 Did the Plan's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	**X** Met __Partially Met __Not Met __Unable to Determine	This is a non-clinical PIP that is clearly focused on improving members' healthcare.
Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.		
1.3 Did the Plan's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	**X** Met __Partially Met __Not Met __Unable to Determine	There is no exclusionary language in this presentation. This PIP is focused on all eligible members within the appropriate age ranges.
Demographics: xx Age Range _____Race _____Gender Medical Population: __xx__ Medicaid Only _____ Commercial	Totals	**3** Met _____Partially Met _____Not Met _____UTD

Step 2: REVIEW THE STUDY QUESTION(S)		
2.1 Was the study question(s) stated clearly in writing?	**X** Met __Partially Met __Not Met __Unable to Determine	This study question, as presented, is identical to the 2014 and 2015 PIPs, including references to data from HEDIS (HY) 2016. No updates have occurred. Later, there is an addendum to the question included, and titled "What Changed": Implement processes to identify non-compliant members, and offer these members opportunities to schedule an appointment with a willing dental provider." With this addition and accompanying explanation, the study question is updated. It is well constructed and addresses the goal of a 3% increase goal from one measurement year to the next. The PIP will continue to target providers and members.
Include study question(s) as stated in narrative: 1. Will member and provider reminders and education improve the HEDIS rate of annual dental visits as evidenced by a 3% increase in 2016 HEDIS annual dental visits? 2. Will the addition of targeted provide-assisted, care-centered promotions and dental events improve the regional HEDIS rates for annual dental visit (ADV) by 3%?	Total	**1** Met ___Partially Met _____Not Met _____UTD
Step 3: Review Selected Indicators		
3.1 Did the study use objective, clearly defined, measurable indicators?	**X** Met __Partially Met __Not Met __Unable to Determine	Denominator: All Aetna Better Health of MO HEDIS eligible members from the ages of 2 through 20 as of December 31, of the measurement year. Numerator: All Aetna HEDIS eligible members from the ages of 2 through 20 who have had at least one dental visit in the measurement year.
List Indicators: The indicator is the rate of Aetna Better Health managed care members from the ages 2 through 20 years who have had at least one dental visit measured by the measured by HEDIS 2010 through 2017.		The indicator presented and explained in the narrative is clear, concise, and measurable. This includes defining the numerators and denominators.

3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	X Met ___Partially Met __ Not Met __ Unable to Determine	This PIP is focused on the process of care -- Improved Annual Dental Visits -- that is strongly associated with improved healthcare outcomes.
Are long-term outcomes implied or stated: xx yes __no __xx Health Status _____Functional Status _____Member Satisfaction _____Provider Satisfaction	Totals	__2__Met ___Partially Met _____Not Met _____UTD
Component/Standard	**Score**	**Comments**
Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did the Plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	X Met __ Partially Met __ Not Met __ Unable to Determine	All eligible MCHP members, ages 2-20, will be included. This is defined and coincides with the NCQA/HEDIS tech specs, as well as the population defined in the Statewide PIP.
Demographics 2 – 20 Age Range _____Gender _____Race Medical Population: __xx__Medicaid Only _____Commercial		
4.2 If the studied included the entire population, did its data collection approach capture all enrollees to whom the study question applied?	X Met __Partially Met __Not Met __Unable to Determine	The study design section on data collection explains the data collection approach, which is designed to captures all enrollees. It explains how the HEDIS administrative data captures all enrollees.
Methods of identifying participants: __xx__Utilization data _____Referral _____Self-identification _____Other	Totals	__2__Met ____Partially Met _____Not Met _____UTD
Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	__Met __Partially Met __Not Met __Unable to Determine	No sampling methodology was used in this PIP

Previous findings from any other source: ___literature review ___baseline assessment of indices ___other		
5.2 Were valid sampling techniques that protected against bias employed?	__Met __Partially Met __Not Met __Unable to Determine	
Specify the type of sampling or census used:		
5.3 Did the sample contain a sufficient number of enrollees?	__Met __Partially Met __Not Met __Unable to Determine	
_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	Totals	__NA__ Met ____Partially Met ____Not Met _____UTD
Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	**X** Met __Partially Met __Not Met __Unable to Determine	A complete study design was presented. It clearly defines all the data to be collected, and the methodology that was used.
6.2 Did the study design clearly specify the sources of data?	**X** Met __Partially Met __Not Met __Unable to Determine	Claims data is received from DentaQuest generated by their claims processing system. They use appropriate CDT codes indicating dental claims. This information is submitted to Aetna Better Health through an established software exchange.
Sources of data: ___Member __xx__ Claims ___Provider _____ Other:		
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	**X** Met __Partially Met __Not Met __Unable to Determine	The narrative explains how the HEDIS ADV rate is calculated for the entire population; how data is then loaded into NCQA certified software by trained IT specialists; and how the HEDIS outcome reports are produced.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	**X** Met __Partially Met __Not Met __Unable to Determine	The administrative methodology is utilized to produce the ADV HEDIS rates. This is described in a manner ensuring consistent and accurate data collection. Who collects data, how it is input into the system, and staff involved in this entire process are included. During 2016, Aetna Better Health staff recognized irregularities in provider reports between the MCHP and DentaQuest. The data received coded some providers as "general practitioners" and recognized them as medical rather than dental. This was corrected by June 2016. It does provide

		evidence that checks within the system produce reliable data.
Instruments used: _____Survey _____Medical Record Abstraction Tool Other: _____		
6.5 Did the study design prospectively specify a data analysis plan?	**X** Met __Partially Met __Not Met __Unable to Determine	The prospective data analysis plan that was presented enhanced the analysis from 2014 through 2016. It was detailed and complete. The narrative includes the specific processes used to analyze data throughout the study year, as well as how this data will be used to assess the success of the planned interventions.
6.6 Were qualified staff and personnel used to collect the data?	**X** Met __Partially Met __Not Met __Unable to Determine	All staff members, their areas of expertise, and rolls in the PIP are presented.
Project Leader Name: Dale Pfaff Title: QM Nurse Consultant Role: Responsible for all aspects of the PIP. Other team members: Names/Roles: Carol Stephens-Jay – data analysis Beginning 03/2017 Project Lead became Sue Holmes. Dr. Angela Miller is the medical director involved.	Totals	**6** Met _____Partially Met ____Not Met _____UTD
Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**X** Met __Partially Met __Not Met __Unable to Determine	This section includes information about successful outcomes in each project year beginning October 2008 through 2016. The Table presented descriptions of these interventions. The major intervention introduced in 2016 was having discussions with one FQHC with a project where they would treat MCHP members who were their patients for dental care. This project had strong potential for providing better and regular dental care to MCHP members in St. Louis City. The plan did develop concrete interventions for this project.

1)Working on building a relationship with one large FQHC, Affinia Healthcare, as a best practice model. Aetna Better Health independently and in collaboration with the Dental Task Force, began conversations with Affinia Healthcare in St. Louis, MO. This FQHC has a new dental facility with 92 dental chairs and is staffed by full-time workers and students from A.T. Still University's Missouri school of Dentistry and Oral health. 2) In June 2016 Aetna Better Health began sending a report to Affinia of their members who were non-compliant in obtaining their annual dental visit for at least six (6) months. The first report sent to Affinia contained 2,500 non-compliant members. Affinia made appointments with 500 of their patients (MCHP members) using that report. Subsequent reports were submitted to Affinia monthly for the remainder of 2016.	Totals	_1_Met _____Partially Met _____Not Met _____UTD
Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	_X_ Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The analysis of the outcomes occurred according the data analysis plan.
This Element is "Not Met" if study is complete and there is no indication of a data analysis plan (see step 6.5)		
8.2 Were the PIP results and findings presented accurately and clearly?	_X_ Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The results are presented clearly and accurately. All outcomes were presented from HEDIS 2008-2017. The information included monthly and year to year comparisons. The HY 2017 results are not audited numbers, as this report was completed in 03/2017. The initial table illustrates MHD goals, goal variance, and growth from the base year and the percentage of change.
Are tables and figures labeled? _xx_ yes __no Are they labeled clearly & accurately? _xx_yes ___no		

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	Data are presented analyzing outcomes from previous reports, and identifying all initial and repeat measurements. Chi-Square Test results are included. This section includes data through HEDIS 2017. The results of their agreement with the FQHC (Affinia) are presented.
Indicate the time periods of measurements: yearly and monthly outcomes are presented. Indicate statistical analysis used: Chi Squared testing has always been used. Indicate statistical significance level or confidence level if available/known: _____99% _xx_95% _____Unable to determine		
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and any follow-up activities?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The MCHP met with Affinia, a large FQHC in St. Louis, who has 92 dental chairs. At the request of the FQHC, Aetna Better Health provided a report to the facility with a list of their members who were non-compliant for at least 6 months. The first report to the facility, submitted in June 2016, yielded over 2,500 unique members who were non-compliant. Affinia reported that they had made appointments for 500 of their patients (MCHP members) using that report. Aetna provided this report to Affinia monthly for the remainder of CY 2016.
Limitations described: This was a pilot project with 1 FQHC. Conclusions regarding the success of the interpretation: The project with Affinia Healthcare indicate a successful intervention. Overall outcomes improvement was limited do to the small portion of the population impacted. Recommendations for follow-up: Use this pilot as a best practice and expand this type of cooperative project with FQHCs statewide.	Totals	**4** Met _____Partially Met _____Not Met __ Not Applicable _____UTD
Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The same methodology was utilized throughout the project. Enhancements occurred when these were appropriate and effectively informed this PIP. Continued improvements are recognized. Updates occurred as necessary.

Ask: Were the same sources of data used? Did the use the same method of data collection? Were the same participants examined? Did they utilize the same measurement tools?		
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	Improvement from 2016 through 2017 did not meet the goal of 3% improvement, based on the HY 2017, which include unaudited rates, without the inclusion of hybrid data. The problem discussed below was documented and corrected. Methods to study the effectiveness of the interventions were presented.
Was there: ____Increase __xx__Decrease Statistical significance ___yes xx no Clinical significance __xx yes ___no There was clinical significance for the second half of 2016 in the pilot area. This success is not reflected in the aggregate data, but in the monthly report for the Eastern Region reflected improvement		Near the end of first quarter 2016, the Senior Data Analyst for Aetna Better Health recognized irregularities in provider reports between the MCHP and DentaQuest. A drill-down helped to identify that Aetna software was not counting dental services provided by dentists listed as "general practitioners," rather it was recognizing those providers as medical, not dental. By June 2016, Aetna and DentaQuest had these irregularities corrected. This problem did affect the overall success of this PIP for 2016.
9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	A detailed analysis is provided for the PIP overall and for improvements, due to the described intervention beginning in the last six months of 2016.
Degree to which the intervention was the reason for change ___No relevance ___Small _x_ Fair ___High		Direct relevance between the outreach efforts and improved ADV rates for the limited time frames are described above.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The narrative describes the efforts made to improve the number of community outreach activities, and implementation of pilot interventions. The data analysis drew a direct correlation between these activities and improved statistics. The limited and regional improvements are considered true improvement that will produce statistical significance over time.
_____Weak __xx__Moderate _____Strong	Totals	**4** Met _____Partially Met _____Not Met ___Not Applicable _____UTD

Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	X Met __ Partially Met __Not Met __ Not Applicable __ Unable to Determine	Aetna Better Health has made improvements to the PIP interventions over the course of the PIP, from HY 2010 through HY 2017. The data presented in this report shows continued growth and that the goal was met through HY 2014. If this PIP was to continue, the MCHP believes sustained improvements would be achieved.
	Total	1 Met _____Partially Met _____Not Met __ Not Applicable _____UTD
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	Comments
Were the initial study findings verified upon repeat measurement?		

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.

Conclusions:
The MCHP has been committed to initiating activities that lead to improved ADV rates. During 2015, specific and focused interventions were not implemented. The interventions achieved in 2016 did produce limited positive results. Changes in the improvement strategy during 2016 indicated that improvements can be achieved, but should be expanded statewide.

Recommendations: Continue the development of baseline data, and implementation of the interventions identified. Continue to explore innovative interventions not used and reused that have lacked the desired impact.

Check one:

- ☐ High confidence in reported Plan PIP results
- **X** Confidence in reported Plan PIP results
- ☐ Low confidence in reported Plan PIP results
- ☐ Reported Plan PIP results not credible
- ☐ Unable to determine – the PIP is new and has produced no results

CONCLUSIONS

QUALITY OF CARE

Both PIPs seek to improve the quality of services to members. The clinical PIP was developed to improve immunization rates, an essential component of preventive services. The non-clinical PIP sought to improve the MCHP's rate of annual dental visits. The clinical PIP did not yet have substantive outcomes to report. Aetna Better Health did not have access to complete HEDIS 2017 results; therefore, analysis of their first year's interventions was not possible. Aetna Better Health experienced success with the interventions previously implemented for the non-clinical project through CY 2014. They did not reach their goals for improvement in CY 2015 or 2016. Future planned initiatives are hoped to produce desired outcomes.

The focus of the clinical PIP was targeted at improving the quality of health care for members by enhancing member's ability to obtain childhood immunizations. Aetna Better Health recognized the importance of helping members obtain services that meet their needs and are of the highest quality. Their goal was to provide quality services to members utilizing MCHP resources while collaborating with community based healthcare agencies to achieve this standard.

ACCESS TO CARE

The clinical PIP had a specific focus on accessing services by engaging providers to assist in making a preventive service available. The study sought to ensure that members' parents/guardians have all the resources necessary to obtain the immunizations their children need. The non-clinical PIP was based on the theory that improving availability, awareness, and access to dental care will improve the overall health of the members served. The supporting documentation indicated that these PIPs had the potential to improve access to services.

TIMELINESS OF CARE

The services and interventions in the clinical PIP were planned to improve the outcomes related to the timeliness of members obtaining required immunizations within a specific time frame. In this PIP, the areas of access, quality, and timeliness of care were of the utmost importance. The MCHP developed projects that supported their efforts to promote timely and appropriate healthcare. Their non-clinical projects were on efforts to improve timeliness of care. The MCHP focused on reaching goals for preventive care in oral health by collaborating with community agencies to develop partners in assisting members in obtaining their annual dental

visits. The interventions employed sought to increase the availability of providers, and expand methods of contacting members, so timely dental care could be achieved. The PIP focused on reducing barriers to obtaining services by partnering with the MCHP Community Outreach staff and community based healthcare providers. The MCHP planned on continuing to enhance this project and improving members' ability to access services on a timely basis through developing new innovative approaches.

RECOMMENDATIONS

1. The MCHP focused their efforts on developing strong new PIPs to impact important aspects of preventive care. They continue to evaluate the effectiveness of PIP interventions throughout the calendar year, as proposed in the PIP submission, to make periodic adjustments in the approach. Report on information obtained and changes are made.
2. The non-clinical interventions did not achieve the stated goals in CY 2015 and 2016. The MCHP should include narrative to assess how the interventions supported the project, and where they failed.
3. The information included in these PIPs was excellent regarding analyzing and understanding the data. The method of reporting outcomes was enhanced by analyzing the impact of the projects interventions each year. This process should continue.
4. The MCHP indicated that the successful processes described in both PIPs will be incorporated in the regular organization processes. This is an important aspect of the PIP process and should continue to ensure that improvements are sustained.

6.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validating Performance Measures Protocol for Aetna Better Health. Aetna Better Health submitted the requested documents on or before the due date of March 7, 2017. The EQRO reviewed documentation between March 7, 2017 and June 22, 2017.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- NCQA RoadMap for the HEDIS 2016 data reporting year;
- HealthcareData.com LLC's Compliance Audit Report for HEDIS 2016;
- Policies and procedures about calculation of HEDIS 2016 rates;
- Meeting minutes on information system (IS) policies;
- A sample of Catalyst's production logs and run controls;
- National Council on Quality Assurance (NCQA)-certified HEDIS software certification report from Catalyst Technologies;
- Data field definitions & claims file requirements of the Corporate Data Warehouse;
- Data files from the Coventry Corporate Data Warehouse containing the eligible; population, numerators and denominators for each of the three measures;
- HEDIS 2016 Data Submission Tool;
- HEDIS 2016 product work plan; and
- Specifications for Measures to be Reported to MO HealthNet by the Managed Care Plans: Data Year 2015.

Data files were submitted by Aetna Better Health for review by the EQRO; these included Statewide and regional files for PPC and regional files for EDV and EDU performance measures.

FINDINGS

Two of the measures being reviewed (Emergency Department Visits and Emergency Department Utilization) were calculated using the Administrative method, and the third measure (Prenatal and Postpartum Care) was calculated using the Hybrid method.

The reported PPC rate was 82.28% for the Prenatal measure and 64.80% for the Postpartum measure. This is the first year the PPC measure has been audited by the EQRO since 2006. These rates were higher than the National Medicaid HMO average for the measures. Aetna Better Health was the only MCHP in Missouri to report rates higher than both the national averages.

This was the second year that the EQRO was requested to validate the information provided by the MCHPs on the June 30 Healthcare Data Quality Template. The measures that the EQRO validated from this report were Emergency Department Visits (EDV) and Emergency Department Utilization (EDU). Both measures are stratified by presenting diagnosis (Behavioral Health; Medical; or Substance Abuse). These are modified measures for the 2016 HEDIS Technical Specifications for Ambulatory Care (AMB); Mental Health Utilization (MPT); and Identification of Alcohol and Other Drug Services (IAD).

MO HealthNet requested that EQRO recalculates these measures and compares the calculations to the data submitted on the June 30 report. The objectives included determining if each MCHP was calculating the measure in the same fashion and determining if the MCHP could reproduce and provide the data used to calculate these modified HEDIS measures. Aetna Better Health was found to be Substantially Compliant with both the EDV and EDU measure calculations. The data provided to the EQRO were recalculated and the results obtained showed little to no bias when compared to the information reported to MO HealthNet by the MCHP.

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate.

Data Integration and Control

The information systems management policies and procedures for rate calculation were evaluated as consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing, and reporting. For all three measures, Aetna Better Health was found to meet all the criteria for producing complete and accurate data. There were no biases or errors found in the way that Aetna Better Health transferred data into the repository used for calculating the 2016 measures.

Documentation of Data and Processes

Although Aetna Better Health uses a proprietary software package to calculate HEDIS measure rates, adequate documentation of this software and its processes was provided to the EQRO for review. The data and processes used for the calculation of measures were acceptable for the HEDIS measure PPC and the two non-HEDIS measures (EDV and EDU). Unlike last year's review, the EQRO could reproduce the numbers reported by Aetna Better Health to MO HealthNet for these measures, the EQRO finds that Aetna Better Health met all criteria that applied for all three measures.

Processes Used to Produce Denominators

Aetna Better Health met all criteria for the processes employed to produce the denominators of the performance measures validated. This involves the selection of eligible members for the services being measured. Denominators in the final data files were consistent with those reported on the DST for the three measures validated. All members were unique; and the dates of birth ranges were valid.

Processes Used to Produce Numerators

Two of the three measures were calculated using the Administrative method (EDV and EDU). The third measure (PPC) was calculated using the Hybrid method. All measures included the appropriate data ranges for the qualifying events (e.g., immunizations; emergency department services dates; and inpatient admit dates) as specified by the HEDIS 2016 Technical Specifications and the modifications for the June 30 report. Appropriate procedures were followed for the sampling of records for medical record reviews.

For the 2016 review, Aetna Better Health reported to MO HealthNet a total number of EDV-Medical visits of 208,570, and the EQRO validated 207,673 hits. The difference of 897 records

shows an overestimate of 0.37%. This is an improvement over the 2015 validation of this measure for Aetna Better Health. In 2015, Aetna Better Health reported 207,717 EDV-Medical visits; however, the data provided to the EQRO only contained a total of 115,823 records to analyze. Therefore, making it impossible for the EQRO to find and validate a total of 207,717 EDV-Medical hits. The difference of 96,595 hits was an overestimate of 40.06%. At the time of the last report, the EQRO attributed this difference to missing records or an incorrect number of hits reported to MO HealthNet on the June 30, 2016 report. Based on the level of accuracy of the 2016 submission, the EQRO attributes the inaccuracy of the 2015 submissions to a compilation error on the part of the MCHP.

For the 2016 review, Aetna Better Health reported to MO HealthNet a total number of EDV-Behavioral Health visits of 2,552, and the EQRO validated 3,655 hits. The difference of 1,103 records shows an underestimate of 0.45% in the calculations. This is consistent with the 2015 validation of this measure for Aetna Better Health. In 2015, for the Aetna Better Health EDV-Behavioral Health findings, the EQRO validated 3,408 hits, whereas the MCHP submitted 2,625. This difference of 783 hits is an underestimate of 0.36%. The EQRO cannot be certain of the reason for the differences between the two rates of hits; however, the data provided for validation did not produce the number of hits reported by the MCHP for the second year in a row. The EQRO believes it is imperative that the MCHP work with the EQRO and MO HealthNet to discuss any differences in expectations for the reported data.

For the 2016 review, Aetna Better Health reported to MO HealthNet a total number of EDV-Substance Abuse visits of 655, and the EQRO validated 822 hits. The difference of 167 records shows an underestimate of 0.07% in the calculations. This is consistent with the 2015 validation of this measure for Aetna Better Health. In 2015, the EQRO validated 701 hits, whereas the MCHP submitted 521 hits to MO HealthNet on the June 30, 2016 report. This difference of 180 hits was an underestimate of 0.07%, which is much closer to the rate validated than the other sub-measures (EDV - Medical and Behavioral Health). However, the EQRO cannot be certain of the reason for the differences between the two rates of hits. The EQRO is certain that the data provided for validation did not produce the number of hits reported by the MCHP.

For the 2016 review, Aetna Better Health reported to MO HealthNet a total number of EDU-Medical visits of 105,013, and the EQRO validated 104,098 hits. The difference of 915 hits is an

overestimate of 0.38%. This is consistent with the 2015 validation when Aetna Better Health reported 106,092, and the EQRO validated 107,060 hits. In 2015, this difference of 968 hits was an overestimate of 0.40% and was attributed to an incorrect calculation in the data submitted to MO HealthNet or an incorrect data submission to the EQRO. The EQRO believes it is imperative that the MCHP work with the EQRO and MO HealthNet to discuss any differences in expectations for the reported data.

For the 2016 review, Aetna Better Health reported to MO HealthNet a total number of EDU-Behavioral Health visits of 2,552, and the EQRO validated 2,611 hits. The difference of 59 records is an underestimate of 0.02% and is an improvement over the 2,172 reported hits and 2,311 validated hits for this measure in 2015. The 2015 difference of 139 hits was an underestimate of 0.06%. The EQRO attributes the MCHP's underestimates to incorrect calculation or identification of variables in the data submitted to MO HealthNet. However, this calculation is more accurate than most of the data submitted for the EDV and EDU measures.

Aetna Better Health more accurately reported the EDU-Substance Abuse visits sub measure than any of the other measures validated by the EQRO. In 2016, Aetna Better Health was the only MCHP to report the same number or hits that were validated by the EQRO, thereby showing no bias in their reporting for this sub measure. In 2015, Aetna Better Health reported to MO HealthNet a total number of EDU-Substance Abuse visits of 417, and the EQRO validated 423 hits. The difference of 6 hits was an overestimate of 0.02% and attributed to an incorrect calculation in the data submitted to MO HealthNet or an incorrect data submission to the EQRO.

Sampling Procedures for Hybrid Methods

The Hybrid Method was used for the Prenatal and Postpartum Care measure: CMS Protocol Attachment XII, and Impact of Medical Record Review Findings and Attachment XV. Sampling Validation Findings were completed for this measure. Aetna Better Health was compliant with all specifications for sampling processes.

Submission of Measures to the State

Aetna Better Health submitted the Data Submission Tool (DST) for the HEDIS measure to the SPHA (the Missouri Department of Health and Senior Services), in accordance with the Code of

State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and MO HealthNet Quality Improvement Strategy. Aetna Better Health submitted data as requested for the June 30 MO HealthNet report.

Determination of Validation Findings and Calculation of Bias

As shown in Table 13, no bias was found in the PPC measure; however, some bias was observed in both the EDV and EDU measures.

Table 23 - Estimate of Bias in Reporting of Aetna Better Health HEDIS 2015 and 2016 Measures.

Measure	Estimate of Bias 2015	Direction of Estimate	Estimate of Bias 2016	Direction of Estimate
Prenatal and Postpartum Care (PPC)	Measure not validated	N/A	None found	N/A
Emergency Department Visits - Medical	40.06%	Overestimate	0.37%	Overestimate
Emergency Department Visits – Behavioral Health	0.36%	Underestimate	0.45%	Underestimate
Emergency Department Visits – Substance Abuse	0.07%	Underestimate	0.07%	Underestimate
Emergency Department Utilization - Medical	0.40%	Underestimate	0.38%	Overestimate
Emergency Department Utilization – Behavioral Health	0.06%	Underestimate	0.02%	Underestimate
Emergency Department Utilization – Substance Abuse	0.02%	Overestimate	None found	N/A

Source: BHC, Inc., 2015 and 2016 External Quality Review Performance Measure Validation.

Final Audit Rating

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure (see Table 24). The rate for the Prenatal and Postpartum measure showed no bias; and was, therefore, deemed Fully Compliant. In 2015, The Emergency Department Utilization measure was found to be both under and overestimated; but it still fell within 1% of the hits reported, so that it was deemed Substantially Compliant. The Emergency Department Visits measure was found to be both over and under estimated, with the Medical visit measure having a bias of over 40%; but this measure was found to be Not Valid. For 2016, both the Emergency Department Utilization and Emergency Department Visit measures were found to be both under and overestimated; but they still fell within 1% of the hits reported, and these were deemed Substantially Compliant.

Table 24 - Final Audit Rating for Aetna Better Health Performance Measures.

Measure	Final Audit Rating
Prenatal and Postpartum Care	Fully Compliant
Emergency Department Visits	Substantially Compliant
Emergency Department Utilization	Substantially Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCHP. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No Managed Care Members qualified for the measure.

CONCLUSIONS

QUALITY OF CARE

Aetna Better Health's calculation of the Emergency Department Utilization measure was substantially compliant with specifications. This measure serves to provide a count of the individual number of members who access the ED for various issues, over the course of the measurement year. This measure provides further detail to the reason for the ED visit, categorizing it as Medical, Behavioral Health, or Substance Abuse. This information is useful for the MCHPs to determine if the ED is being utilized properly by its members.

Aetna Better Health's rate for the EDU-Medical measure was higher than the average of all MCHPs, indicating that a higher percentage of Aetna Better Health's members are accessing the ED for Medical issues than that of the other MCHPs. Aetna Better Health's rates for the EDU-Behavioral Health and EDU-Substance Abuse measure were lower than the average for all MCHPs, indicating that a lower percentage of Aetna Better Health's members are accessing the ED for Behavioral Health and Substance Abuse issues, which were less than that of the other MCHPs.

ACCESS TO CARE

The Emergency Department Visit measure was rated as substantially compliant with specifications. This measure is an Access to Care measure as it measures the number of ED visits recorded for the MCHP. Aetna Better Health's rate for the EDV- Medical measure was higher than the average for all MCHPs, indicating that Aetna Better Health's members are accessing the ED for Medical issues at a rate higher than that of the other MCHPs. Aetna Better Health's rates for the EDV-Behavioral Health and was lower than the average for all MCHPs, indicating that Aetna Better Health's members are accessing the ED for Behavioral Health issues less often than that of the other MCHPs.

TIMELINESS OF CARE

The MCHP's calculation of the HEDIS 2016 Prenatal and Postpartum Care (PPC) measure was fully compliant. This measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received. The MCHP's reported rate for this measure was **higher** than the average for all MCHPs and was **higher** than National Medical HMO Average

for Postpartum Care. This was the first time that this measure was audited by the EQRO since 2006.

More of Aetna Better Health's members are receiving Postpartum care in a timelier manner in this measure than that of other MCHPs and the average Medicaid HMO across the nation.

RECOMMENDATIONS

1. Continue to utilize the Hybrid methodology for calculating rates when allowed by the specifications.
2. Continue to conduct and document statistical comparisons on rates from year to year.
3. Work to increase rates for the Prenatal measure; although it was higher than the average for all MCHPs, this rate was below the National Medicaid averages.
4. Provide information as requested in the EQRO's data request.

6.3 MCHP Compliance with Managed Care Regulations

METHODS

Aetna Better Health of Missouri (Aetna Better Health) was subject to a follow-up compliance audit. The content of this 2016 calendar year audit included follow-up to all components of the Quality Standards as defined in 42 CFR 438 that were found to be lacking during the 2015 review. Evaluation of these components included the reviews of:

- Defined organizational structure with corresponding committee minutes
- Policies and Procedures
- Organizational protocols
- Print materials available to members and providers
- Report results

The Team utilized an administrative review tool which was developed based on the CMS Protocol Assessment of Compliance with Medicaid Managed Care Regulations (Compliance Protocol). The evaluation included the review of Aetna Better Health's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, Aetna Better Health will be evaluated on the timeliness, access, and quality of care provided. This report incorporates a discussion of the MCHP's strengths and weaknesses with recommendations for improvement to enhance overall performance and compliance with standards.

The EQRO rating scale remains as it was during the last evaluation period:

M = Met

Documentation supports that all components were implemented, reviewed, revised, and/or further developed.

PM = Partially Met

Documentation supports some but not all components were present.

N = Not Met

No documentation found to substantiate this component.

N/A = Not Applicable.

Component is not applicable to the focus of the evaluation. N/A scores will be adjusted for the scoring denominators and numerators.

A summary of compliance for all evaluated Quality Standards is included in Table 25.

Table 25 - Aetna Better Health Compliance Ratings for Compliance Review Years (2014-2016).

Measure	2014	2015	2016
Enrollee Rights and Protections	100%	100%	100%
Access and Availability	76.47%	76.47%	64.71%
Structure and Operations	100%	100%	100%
Measurement and Improvement	100%	81.82%	90.91%
Grievance Systems	100%	100%	100%

Source: BHC, Inc., 2014-2016 External Quality Review Compliance Validation.

The review of Quality Standards was completed using a Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

FINDINGS

Enrollee Rights and Protections

Enrollee Rights and Protections address 13 standards. For the 2016 review, Aetna Better Health was rated by the review team to have met all 13 standards. This rating of 100% compliance is consistent with the ratings received in 2014 and 2015.

The rating for Enrollee Rights and Protections (100%) reflects Aetna Better Health's ability to have all policy and procedures submitted and approved by MO HealthNet in a timely manner for the seventh consecutive year, and to have practices in place that reflect these policies. The MCHP provided evidence of their practice throughout the on-site review process. It appears that Aetna Better Health follows all Managed Care contract regulations and federal requirements.

A strong commitment to member rights continues to be a cornerstone of Aetna Better Health's service philosophy. The emphasis placed on continuous quality improvement by the MCHP was apparent in both the documentation reviewed and throughout staff interviews. As observed in prior reviews, quality services to members, with an emphasis on families and children, were observed within the organization. Aetna Better Health views cultural diversity as an essential

component of their interactions with members. The MCHP maintains cultural diversity as a cornerstone of initial and ongoing staff training.

Access Standards

Access and Availability addresses 17 standards. For the 2016 review, Aetna Better Health was rated by the review team to have met 11 standards. This is an overall rating of 64.71% compliance, this is lower than the 76.47% compliance found in the prior two years' reviews.

The rating regarding Compliance with Access Standards was affected by these factors:

- Availability of their provider network; specifically, the accuracy of the provider website and availability of providers;
- In reviewing records, full evidence of assessments and treatment planning for members was not available; and
- Case Managers did not recognize the need for Care/Case Coordination in many of the files reviewed.

The records reviewed did not always contain comprehensive assessments of member needs, and evidence of treatment planning or referrals to specialists when appropriate.

Structures and Operations

The area of Structures and Operations addresses 10 standards. For the 2016 review, Aetna Better Health was rated by the review team to have met all 10 standards. This rating is consistent with the ratings received in 2014 and 2015. The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the seventh year. The MCHP appears to be compliant with all policy and practice in this area that meets MO HealthNet contract compliance and federal regulations.

Aetna Better Health's provider advisory group is operational in all three MO HealthNet Managed Care regions. The committee consists of high volume providers and representatives from across specialties. The sharing of ideas and information pertaining to any member dissatisfaction is encouraged. These groups seek provider feedback and provide information in a framework that allows the MCHP to develop a true partnership with their provider network.

Measurement and Improvement

The area of Measurement and Improvement addresses 11 applicable standards. For the 2016 review, Aetna Better Health was rated by the review team to have met 10 of these standards. This 90.91% rate is higher than the 2015 rate of 81.82% and lower than the 2014 rating of 100%.

Aetna Better Health submitted two Performance Improvement Projects (PIPs) for validation. One PIP was well-constructed and provided adequate information for validation. Both PIPs received a rating of 100%.

Grievance Systems

Grievance Systems addresses 18 standards. For the 2016 review, Aetna Better Health was rated by the review team to have met all 18 standards. This is an overall rating of 100% compliance, which is **consistent** with the rating received in 2014 and 2015.

Ratings for compliance with the Grievance Systems regulations indicate that the MCHP completed the requirements regarding policy and practice.

CONCLUSIONS

Aetna Better Health continues to exhibit a commitment to completing, submitting, and gaining approval of required policy and procedures by MO HealthNet, and developing operations that ensure that these procedures are reflected in daily operations. The MCHP achieved 100% compliance in three of the five sections of the Compliance protocol.

The MCHP incorporates methods to track required policy submission into daily administrative practice and took this process seriously. The practice observed at the time of the on-site review provided confidence that services to members are their primary focus and that there was a commitment to comply with the requirements of the Managed Care contract and federal regulations.

Quality of Care

The Aetna Better Health provider relations staff made regular contacts with providers to troubleshoot problems that may be reported by members, and to assist provider staff in making interactions with members and the MCHP less complicated. The EQRO did not receive documentation of all the quality services required. Treatment planning, assessments, and care coordination were areas that the EQRO could not fully validate.

Access to Care

Aetna Better Health provided numerous examples of initiatives that are involved in to ensure that members have information on obtaining services and having adequate access to services. The MCHP has undertaken provider recruitment and retention efforts to ensure that providers are available to members throughout all three MO HealthNet Managed Care Regions served. However, the EQRO did find the MCHP's website to be riddled with inaccuracies and fewer providers accepted new patients than reported. Further information regarding the Website Accuracy Survey may be found at http://dss.mo.gov/mhd/mc/pdf/health-plan-website-accuracy-new-patient-acceptance-rates-report.pdf.

Timeliness of Care

Aetna Better Health could complete all required policies and procedures in a timely manner, to ensure compliance with State contract requirements and federal regulations. The focus on obtaining timely health care services and responses to member needs reflects the attention needed to effectively provide a managed system of services to members.

Recommendations

1. Make every effort to supply the EQRO with all relevant information for every case file, grievance file, policy, or procedure requested.
2. Retain the focus on complying with documentation requirements to the same standards as those reflected in the daily practice within the MCHP.
3. Maintain involvement in community-based services and activities.
4. Continue to monitor provider and hospital networks for adequacy. Develop contracts were possible.

7.0 Home State Health

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7.1 Performance Improvement Projects

Document Review

Home State Health supplied the following Performance Improvement Project (PIP) documentation for review:

- Improving Immunization Rates in Home State Health Members in the First 2 Years of Life
- Improving Oral Health

Interviews

Interviews were conducted with the following project leaders for each PIP by the EQRO team on June 22, 2016 during the on-site review:

- Megan Barton – Vice President of Medical Management
- Dana Houle – Director, Quality Improvement
- Dale Pfaff – Manager, Quality Improvement
- Laura Rundell – Quality Improvement Intern

Interviewees shared information on the validation methods, study design, and findings of the PIPs. The following questions were discussed; and technical assistance was provided by the EQRO to the MCHP:

- What instruments are used for data collection?
- How were accuracy, consistency, and validity assured?
- What did the MCHP hope to learn from the findings relevant to the MO HealthNet Managed Care population?
- How was improvement analyzed?
- What are the conclusions about the effectiveness of the interventions so far?

The MCHP was given an opportunity to provide an updated submission following the on-site review. The information evaluated here is based on the enhanced submissions and additional data that were supplied.

FINDINGS

CLINICAL PIP – IMPROVING IMMUNIZATION RATES IN HOME STATE HEALTH MEMBERS IN THE FIRST 2 YEARS OF LIFE

Home State Health's clinical PIP was implemented in July 2015. The MCHP recognized that childhood vaccinations protect children from serious and potentially life-threatening diseases, such as diphtheria, measles, meningitis, polio, tetanus, and whooping cough, at a time in their lives when they are most vulnerable to disease. The goal of this project is to ensure that members receive all appropriate immunizations by age 2. The MCHP is implementing this PIP to attain a target rate of 90% for the number of 2-year-olds who receive the necessary vaccinations by the completion of this project.

Home State Health identified that a lack of parental knowledge, and misinformation regarding the benefits of immunizations, hinder members from obtaining their vaccinations. These include:

- Lack of knowledge and a belief that immunizations do not protect children from serious illness;
- Belief that immunizations are not safe and effective at protecting children from disease;
- Lack of knowledge that immunizations are required for school and child care activities; and
- Lack of knowledge about the importance of each child obtaining immunizations to protect the community.

The MCHP designed the following interventions to assist in ameliorating this problem:

Member Interventions

- Implementation of an Early Periodic Screening, Diagnostic, and Treatment (EPSDT) program with St. Louis Medical.
- New Mom and Traditional EPSDT tangible incentive and texting programs aimed at educating parents in their preferred mode of communication, and incentivizing healthy behaviors, including childhood immunizations.

Provider Interventions

- Provider Care Gap Closure incentive to nine participating FQHCs where health centers close all gaps in HEDIS measurable care for a $25 incentive per member.

- Education at practitioner offices on accurate coding practices.
- Pay for Performance agreements with hospital systems that include electronic HEDIS Combo 10 immunization data.

Home State Health Interventions

- Collaborate with the Missouri School Nurses Association for enhanced processes allowing parents to grant school nurses permission to communicate with Home State Health.
- Refine data submission processes with Missouri Health Plus (a network of community health centers with teams of caregivers who are dedicated to the patient. It stands for the primary care, plus extra services such as prenatal care, health education, access to nutritionist, and more), and increased the immunization included from HEDIS Combo 3 to Combo 10.
- Enhance partnership with County Health Departments for year-round medical record retrieval.

The results of CY 2016 efforts were a decline in both Combo 3 and Combo 10 rates from CY 2015 to 2016 (-0.24 percentage points for Combo 3; -2.40 percentage points for Combo 10). The rates for both Combo 3 and Combo 10 did not achieve the outcomes of meeting or exceeding the established goals for this project. Home State Health currently plans to continue with the infrastructure changes. The MCHP will assess the more direct interventions with members including educational and informational materials intended to increase their understanding of wellness behaviors. Home State Health will focus on its interventions with providers intended to close care gaps by involving providers, and using outreach telephone calls to directly communicate with members.

Home State Health is committed to achieving the goals of this PIP. They are putting new interventions in place, while maintaining current interventions that have promise to produce long-term change.

The following Validation Worksheet provides the details of how the project met each PIP requirement:

Demographic Information		
Plan Name or ID: Home State Health		
Name of PIP: Improving Childhood Immunization Rates		
Dates in Study Period: 7-1-2015 - Present		
I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
Step 1: REVIEW THE SELECTED STUDY TOPIC(S)		
Component/Standard	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	**X** Met __Partially Met __ Not Met __ Unable to Determine	The Study Topic discussion delves into the current statistics for children obtaining immunizations on the national, state, and MCHP levels. The narrative provides a convincing argument for choosing this issue. They understand that this PIP is required by their current MHD contract. However, the overarching argument is that this is an issue pertinent to Home State Health members. The MCHP argues that by using the PIP process, they can impact in a member health in a positive manner. The discussion clearly identifies the health care benefits to their members. The topic discussion exhibited depth in analyzing research data, and applying this information to improve member needs, care, and services
Clinical xx Prevention of an acute or chronic condition xx High volume services ___Care for an acute or chronic condition ___High risk conditions		The narrative updates the topic discussion to address its applicability to the current measurement year. The discussion states Home State Health's goal of increasing the number of members ages 0-2, obtaining Combo 10 immunizations by 4 percentage point each year for a 3-year period.
Non-Clinical ___Process of accessing or delivering care		
1.2 Did the Plan's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	**X** Met __Partially Met __Not Met __Unable to Determine	Timely and complete immunizations are an essential aspect of member care/services. Focusing on these issues emphasizes the importance of preventive services.
Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.		
1.3 Did the Plan's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	**X** Met __Partially Met __Not Met __Unable to Determine	All members up to age 2. No children, including children with SHCNs are excluded.
Demographics: xx Age Range _____Race _____Gender Medical Population: _____ Medicaid Only _____ Commercial	Totals	**3** Met _____Partially Met _____Not Met _____UTD

Step 2: REVIEW THE STUDY QUESTION(S)		
2.1 Was the study question(s) stated clearly in writing?	**X** Met __Partially Met __Not Met __Unable to Determine	The study question is concise and states the goal for this project. It is updated from the previous year's study question – and is focused on the CY 2016 PIP.
Include study question(s) as stated in narrative: Will directing targeted member and provider health promotion and awareness activities increase the percentage of HSH children (age birth – 2) who are immunized, by 4 percentage points each year over three years?	Total	**1** Met ___Partially Met _____Not Met ___ UTD
Step 3: Review Selected Indicators		
3.1 Did the study use objective, clearly defined, measurable indicators?	**X** Met __Partially Met __Not Met __Unable to Determine	The objective of the PIP is to improve the number of children birth-2 who receive all required immunizations, which will be measured by improvements in the CIS HEDIS measure. Home State Health will use administrative and hybrid data to determine their HEDIS rate annually.
List Indicators: CIS HEDIS rate for Combo 10		
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	**X** Met ___Partially Met __ Not Met __ Unable to Determine	Home State Health will use this HEDIS measure to evaluate outcomes of the efforts made in this PIP. The narrative states that they will monitor the indicators through the year, at least quarterly, to evaluate the effectiveness of their interventions.
Are long-term outcomes implied or stated: xx yes __no xx Health Status _____Functional Status _____Member Satisfaction _____Provider Satisfaction	Totals	**2** Met ___Partially Met _____Not Met _____UTD
Component/Standard	**Score**	**Comments**
Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		

4.1 Did the Plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	**X** Met __ Partially Met __ Not Met __ Unable to Determine	The study population is all children 0-2. The enrollment "allowable gap" criteria will not be used for the intervention population.
Demographics xx Age Range _____Gender _____Race Medical Population: xx Medicaid Only _____Commercial		
4.2 If the studied included the entire population, did its data collection approach capture all enrollees to whom the study question applied?	**X** Met __Partially Met __Not Met __Unable to Determine	Interventions include all members ages birth though 2.
Methods of identifying participants: xx Utilization data _____Referral _____Self-identification _____Other _____	Totals	**2** Met ____Partially Met _____Not Met _____UTD
Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	__Met __Partially Met __Not Met __Unable to Determine	No sampling methodology was used in this PIP.
Previous findings from any other source: ___literature review ___baseline assessment of indices ___other		
5.2 Were valid sampling techniques that protected against bias employed?	__Met __Partially Met __Not Met __Unable to Determine	
Specify the type of sampling or census used:		
5.3 Did the sample contain a sufficient number of enrollees?	__Met __Partially Met __Not Met __Unable to Determine	
_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	Totals	NA Met ____Partially Met ____Not Met _____UTD
Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	**X** Met __Partially Met __Not Met	The narrative provides a description of how HEDIS data is obtained, why this is reliable, and how all data regarding this measure will be utilized.

	__Unable to Determine	
6.2 Did the study design clearly specify the sources of data?	X Met __Partially Met __Not Met __Unable to Determine	The sources of data described include internally obtained administrative data, and year-round medical record retrieval. Home State Health is evaluating their program data, and is working with County Health Departments, and rural providers to obtain all available data that informs the outcomes after interventions are in place. Hybrid records are reviewed and evaluated by an independent contractor.
Sources of data: ___Member __xx__Claims ___Provider xx Other: medical record review.		
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	X Met __Partially Met __Not Met __Unable to Determine	The methods outlined above create a system that allows collection of valid and reliable data. This applies to the hybrid and administrative data.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	X Met __Partially Met __Not Met __Unable to Determine	All CPT codes used to determine compliance are identified. The methods and systems employed for data collection are designed to provide consistent and accurate data. The medical record retrieval program is explained in detail. Home State Health provided their data for 2015, which is their baseline year; and for 2016, the first year of PIP implementation.
Instruments used: _____Survey __xx__Medical Record Abstraction Tool Other: _____		Inclusion of a description of how medical records are accessed for the hybrid measure was obtained.
6.5 Did the study design prospectively specify a data analysis plan?	X Met __Partially Met __Not Met __Unable to Determine	All data to be collected, and where this data is provided. The narrative describes processes for collecting data monthly. A monthly care gap report is used to identify members who have not met the measure specifications. QI staff will extract monthly preliminary HEDIS results to analyze and determine the effectiveness of interventions in place. Results of medical record review will be integrated into the administrative data. The final step in the data analysis plan is to assess rates and determine future steps that the MCHP should take to alter member/provider behaviors to achieve substantial changes in the number of members receiving immunizations.
6.6 Were qualified staff and personnel used to collect the data?	X Met __Partially Met __Not Met __Unable to Determine	

Project Leader Name: Dana Houle Title: Director of Quality Improvement Role: Project oversight, including data collection and interpretation. Other team members: Data Analyst – as HEDIS Coordinator, QI Coordinator analysts, call center staff marketing and communications staff and member connections staff complete the team.	Totals	**6** Met _____Partially Met ____Not Met _____UTD
Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**X** Met __Partially Met __Not Met __Unable to Determine	The description of the interventions is somewhat confusing. However, all necessary information is available to assess that reasonable interventions are in place. There is narrative explaining some initiatives, plus a table categorizing them. If the information on the table was organized in order by member/provider/plan, it would provide clarity.
Describe Intervention(s): **Member**: Implementation STL Medical New Mom and Traditional EPSDT tangible incentive and texting programs aimed at educating parents in their preferred mode of communications and incentivizing healthy behaviors, including childhood immunizations. **Providers**: Provider Care Gap Closure incentives to 9 FQHCs where health centers close all gaps in HEDIS measurable care for a $25 incentive/member; Education at practitioner offices on accurate coding practices; Pay for Performance agreements with hospital systems that include electronic Combo 10 immunization data. **Plan**: Collaboration with MO School Nurse Assn., for enhanced processes allowing parents to grant school nurses permission to communicate with the health plan (sharing immunization records); Refined data submission process with MO Health Plus and increased the immunizations included from Combo 3 to Combo 10; Enhanced partnership with County Health Departs, in year- round medical record retrieval.	Totals	**1** Met ___Partially Met _____Not Met _____UTD
Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The plan for data analysis was followed. The data available includes the baseline year, 2014; the first measurement year, 2015; and the outcomes for 2016. The plan did experience initial success. They do credit this to a combination of the use of the hybrid method of data collection, and the interventions implemented to date.

This Element is "Not Met" if study is complete and there is no indication of a data analysis plan (see step 6.5)		
8.2 Were the PIP results and findings presented accurately and clearly?	X Met __Partially Met __Not Met __Not Applicable __Unable to Determine	Results comparing HEDIS 2015, HEDIS 2016, and HEDIS 2017 are presented. The tables and graphs included are clear and accurate.
Are tables and figures labeled? xx yes __no Are they labeled clearly & accurately? xx yes ___no		
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	__Met X Partially Met __Not Met __Not Applicable __Unable to Determine	The information presented, which included the baseline and 2 measurement years, does identify their initial and repeat measures. Home State Health asserts that they experienced a 32% increase in membership in 2015 and again 2016, which impacted the HEDIS outcomes. However, this argument appears to have minimal impact on the rates. The eligible population is children who reach their 2nd birthday during the measurement year, and who were continuously enrolled for 12 months prior to the child's second birthday. These factors would eliminate most new members from the population included in each year's HEDIS population.
Indicate the time periods of measurements: Annual – January through December of each calendar year. Indicate statistical analysis used: Chi-square testing. Indicate statistical significance level or confidence level if available/known: _____99% xx 95% ___Unable to determine		
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and any follow-up activities?	__Met X Partially Met __Not Met __Not Applicable __Unable to Determine	The analysis presented includes an interpretation of the data presented. It discussed the success or lack of success achieved when presenting HEDIS data in a year-to-year comparison. Home State Health asserts that the member and provider incentives related to texting and electronic data exchanges and various care gap closure processes will address any identified barriers. However, the aggregate HEDIS rates decreased from 57.69% to 57.45%. Although this is not a statistically significant decline, it appears that the interventions did not produce the hoped-for results.

Limitations described: Barriers are presented. How these barriers impact the study was not discussed. Conclusions regarding the success of the interpretation: Not presented. Recommendations for follow-up: A plan for assessing the need for more direct member interventions was mentioned.	Totals	**2** Met **2** Partially Met _____Not Met __ Not Applicable _____UTD
Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	Home State Health has used the same methodology for member eligibility, data collection, and analysis, since this project started.
Ask: Were the same sources of data used? Did the use the same method of data collection? Were the same participants examined? Did they utilize the same measurement tools?		
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	__Met **X** Partially Met __Not Met __Not Applicable __Unable to Determine	There was some improvement in the Eastern and Central MHD Regions from 2015 – 2016. There was a decrease in the Western Region (55.05%/2015 – 46.63%/2016), and a slight decrease in the Statewide outcomes. Home State Health recognized that the interventions utilized have not produced their desired results. They did not venture any hypothesis about why they achieved their current outcomes.
Was there: _____ Increase __xx__ Decrease Statistical significance ___yes __xx__ no Clinical significance ___yes __xx__ no		This is based on aggregate outcomes.
9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	__Met **X** Partially Met __Not Met __Not Applicable __Unable to Determine	There was a decline in HY 2017 outcomes in 1 region and a slight increase in 2 regions, but the statewide rate indicates a decrease. The impact of the interventions is negligible based on the HY 2017 rates. Home State Health's plan for real improvement is based on full implementation of the interventions described, as well as expanded interventions planned for CY 2017. They completed expansion of interventions in the 4th quarter of CY 2016, which the MCHP believes will produce the desired outcomes.
Degree to which the intervention was the reason for change ___No relevance __xx__ Small ___ Fair ___High		

9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	Based on the available data, and length of time this PIP has been in place, this is considered not applicable.
_____Weak _____Moderate _____Strong	Totals	**1** Met **2** Partially Met _____Not Met **1** Not Applicable _____UTD
Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	__ Met __ Partially Met __Not Met **X** Not Applicable __ Unable to Determine	This PIP has not been in place long enough to assess sustained improvement.
	Total	_____Met _____Partially Met _____Not Met **1** Not Applicable _____UTD
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	Comments
Were the initial study findings verified upon repeat measurement?		

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS:
SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.

Conclusions:
Home State Health is working on an important aspect of preventive care. They have created a sound foundation for a successful PIP. Continued analysis regarding the impact on interventions that are in place, and requirements for new innovative interventions has not yet occurred.

Recommendations:
1) The interventions put in place during 2016 should be evaluated to assess their impact for producing change;
2) The PIP mentions implementing more:
   - Direct member educational and informational materials;
   - Focusing on closing care gaps by provider involvement; and
   - Completing more member outreach telephone calls.

   Look at potential success, and evaluate what might truly impact members to change their behavior. Home State Health PIPs, in past years, recognized that sending mailers did not have the desired impact. Before repeating

interventions that were less than effective, it evaluated new interventions for their potential to produce desired results, before investing time and money.

3) Analyze not just the numerical data presented, but also the direct impact that the interventions had on member behavior. This is the foundation of a sound study.

Check one:

☐ High confidence in reported Plan PIP results
☐ Confidence in reported Plan PIP results
☐ Low confidence in reported Plan PIP results
☒ Unable to determine – the PIP is new and has produced no results

NON-CLINICAL PIP – IMPROVING ORAL HEALTH

Home State Health presented information related to the statewide PIP study topic and included an explanation of how this project was pertinent to their members. The study topic presentation was thorough and focused on enhancing available and preventive dental care.

The interventions underway in 2016 were:

Member Interventions:

- Partnership with Clarity Health Clinics to ensure Home State Health members are targeted and treated in the Hannibal area – including Marion, Ralls, Monroe, Montgomery and Pike Counties. The MCHP also developed a fluoride varnish program, and initiated this project with Clarity school nurses.
- Partner with Evolve Dental to attend Affinia sponsored health fairs. The MCHP contacted members in advance to make appointments.
- Evolve Dental will mail a letter and a toothbrush package to members visiting Emergency Departments for dental issues.
- Beginning in July 2106, existing eligible members received a Primary Care Dental (PCD) assignment. ID cards were mailed.

Provider Interventions:

- Provider Incentive for Care Gap Closure with Missouri Health Plus, which included the ADV Measure.

The Home State Health ADV rate for HY 2016 was 40.90%. The goal was to improve the MCHP's ADV rate by 3 percentage point with the goal for HY 2017 of 43.90%. Home State Health did not meet this goal for HY 2017, as the rate was 39.91% reflecting of decline of .99 percentage points. Home State Health's assessment of the declining rates from HY 2015 (42.78%) to HY 2017 (39.91%) provided the following information:

- "Many of the interventions are forward looking and structural in nature. The partnerships with the Missouri Health Plus, St. Louis Medical and Evolve Dental are designed to engage both members and providers to increase awareness and access to care.

- The precipitous increase in membership, somewhat due to auto-enrollment, increases members who are not acclimated, nor familiar with the managed care processes; and do not have an established relationship with the MCHP, nor a provider."

Home State Health additionally identified process problems with the interventions. They provide reasons why the interventions employed in both HY 2016 and HY 2017 did not yield the increases they anticipated:

- The initiative with St. Louis Medical provides the member with a toothbrush, floss and toothpaste, along with a card informing the parent of how to locate a dental provider. This is informative, but does not actually create a visit to the dentist. Home State Health plans to continue this intervention through HY 2018, but did not provide details about any changes that might produce the required dental visit.
- The utilization of dental vans did not yield an increase in the ADV rate, although this intervention is designed to add convenience to an actual visit. The van providers refused to comply with billing standards that would become numerator compliant. Home State Health planned to work with selected vendors to identify a partner who can deliver on a larger and more meaningful scale.
- Affinia Healthcare, a large FQHC with over 90 dental chairs, had administrative and provider challenges which restricted forecasted volumes of treatments. Home State Health will continue to partner with Missouri Health Plus to work with all FQHCs, including Affinia, due to the potential they offer in generating positive ADV rates in the Eastern Region.

Home State Health will continue to assess and monitor the above interventions, and new and innovative approaches to provide dental services to the eligible population. The MCHP states that with the involvement of their Quality Improvement Team's efforts, as well as their collaboration with Missouri Health Plus provider incentives, they will reach their goals.

Home State Health witnessed a decrease in the past two years in their overall ADV rates. The MCHP has committed to many long-term projects designed to empower providers with the ability to identify non-compliant members and to conduct assessments, treatments and referral of members with oral health problems. Home State Health has also promoted long-term plans

for members to develop a Dental Home, receive fluoride varnish, and have more choices for dental access.

The following Validation Worksheet provides the details of how the project met each PIP requirement:

Demographic Information
Plan Name or ID: Home State Health
Name of PIP: Improving Access to Oral Healthcare
Dates in Study Period: 07/01/2013 – to Present

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1: REVIEW THE SELECTED STUDY TOPIC(S)

Component/Standard	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	**X** Met __ Partially Met __ Not Met __ Unable to Determine	The basis of the information presented in the topic discussion is taken from the language of the Statewide Improving Oral Health Initiative. However, Home State Health used information pertinent to their plan and members to enhance the discussion of the need for annual dental visits.
Clinical ___Prevention of an acute or chronic condition ___High volume services ___Care for an acute or chronic condition ___High risk conditions		
Non-Clinical **xx** Process of accessing or delivering care		
1.2 Did the Plan's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	**X** Met __Partially Met __Not Met __Unable to Determine	This is Home State Health's response to the Statewide PIP initiative. It is focused on improving the rate of Annual Dental Visits and improving oral health. The intention of this project is to correct a deficiency in care.
Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.		
1.3 Did the Plan's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	**X** Met __Partially Met __Not Met __Unable to Determine	All plan members who are eligible for dental care are recognized in the narrative. The statewide PIP (via the HEDIS tech specs) is set up to address members ages 2-20. This PIP is focused on the children ages 2-20 population.
Demographics: 2-20 Age Range _____Race _____Gender Medical Population: _____ Medicaid Only _____ Commercial	Totals	**3** Met _____Partially Met _____Not Met _____UTD

Step 2: REVIEW THE STUDY QUESTION(S)		
2.1 Was the study question(s) stated clearly in writing?	**X** Met __Partially Met __Not Met __Unable to Determine	The study question is clear and concise and has been updated for HY 2017.
Include study question(s) as stated in narrative: "Will implementing the proposed interventions to Home State Health members 2 through 20 years of age, increase the rate of annual dental visits per the HEDIS specifications by 5% between HSH's HEDIS 2016 and 2017 results?"	Total	**1** Met ___Partially Met _____Not Met _____UTD
Step 3: Review Selected Indicators		
3.1 Did the study use objective, clearly defined, measurable indicators?	**X** Met __Partially Met __Not Met __Unable to Determine	The study indicators presented were clear and measurable. The numerator and denominator are defined. Although HEDIS rates are determined annually, Home State Health intends to monitor study progress at least quarterly to assess the performance of the interventions that are in place.
List Indicators: Annual HEDIS ADV rates.		
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	**X** Met ___Partially Met __ Not Met __ Unable to Determine	The indicators measure the improvement in the process of care strongly related to improving child health by ensuring the receipt of proper dental care.
Are long-term outcomes implied or stated: __yes __no xx Health Status xx Functional Status _____Member Satisfaction _____Provider Satisfaction	Totals	**2** Met ___Partially Met _____Not Met _____UTD
Component/Standard	**Score**	**Comments**

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did the Plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	**X** Met __ Partially Met __ Not Met __ Unable to Determine	The project includes all MCHP members 2 – 20 years of age. The enrollment "allowable gap" criteria will not be applied to the intervention population. All eligible members in this age range will have access to the interventions.
Demographics: 2-20 Age Range _____Gender _____Race Medical Population: xx Medicaid Only _____Commercial		
4.2 If the studied included the entire population, did its data collection approach capture all enrollees to whom the study question applied?	**X** Met __Partially Met __Not Met __Unable to Determine	The data collection procedures described are consistent with the use of HEDIS data. They are clear and consistent and apply to all members to whom the study applies.
Methods of identifying participants: xx Utilization data _____Referral _____Self-identification _____Other _____	Totals	**2** Met ____Partially Met _____Not Met _____UTD
Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	__Met __Partially Met __Not Met __Unable to Determine	No Sampling methods are used in the PIP.
Previous findings from any other source: ___literature review ___baseline assessment of indices ___other		
5.2 Were valid sampling techniques that protected against bias employed?	__Met __Partially Met __Not Met __Unable to Determine	
Specify the type of sampling or census used:		
5.3 Did the sample contain a sufficient number of enrollees?	__Met __Partially Met __Not Met __Unable to Determine	
_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	Totals	NA Met ____Partially Met ____Not Met _____UTD

Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	X Met __Partially Met __Not Met __Unable to Determine	The narrative explains the data to be collected, and the sources of the data. It explains the administrative method for gathering HEDIS data, and how they will integrate information from Missouri Health Plus and Dental Health and Wellness into their data systems.
6.2 Did the study design clearly specify the sources of data?	X Met __Partially Met __Not Met __Unable to Determine	The sources of all data and how it is gathered are explained in detail. Data will be collected from various sources and loaded in the Centene Enterprise Data Warehouse.
Sources of data: ___Member _xx_ Claims ___Provider _____ Other:		
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	X Met __Partially Met __Not Met __Unable to Determine	The methodology for collecting valid and reliable data was provided in detail.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	X Met __Partially Met __Not Met __Unable to Determine	Administrative data is used to determine the HEDIS rate. All methods of collecting and analyzing the data is presented. It is clear and understandable.
Instruments used: _____Survey _____Medical Record Abstraction Tool Other: _____		
6.5 Did the study design prospectively specify a data analysis plan?	X Met __Partially Met __Not Met __Unable to Determine	Home State Health uses administrative data that is extracted monthly. Monthly preliminary HEDIS data are used to analyze and determine effectiveness of interventions based on observed changes in the ADV rate throughout the measurement year. Home State Health runs the ADV measure without the continuous enrollment factor to determine if all members, particularly those who are non-compliant, are outreached in a timely fashion.
6.6 Were qualified staff and personnel used to collect the data?	X Met __Partially Met __Not Met __Unable to Determine	

Project Leader Name: Dana Houle Title: Director of Quality Improvement Role: Project oversight, including data collection and interpretation Other team members: Names/Roles: Data Analyst – as HEDIS Coordinator; QI Coordinator analysts, call center staff, marketing and communications staff and member connections staff complete the team.	Totals	**6** Met _____Partially Met ____Not Met ____UTD
Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**X** Met __Partially Met __Not Met __Unable to Determine	Interventions that started in the 4th quarter of 2015 are included as new, as any impact would be reflected in the 2016 (HY 2017) rates. The interventions described all had promise. However, two were limited geographically. There was no discussion about how these can be expanded statewide, if successful.
Describe Intervention(s): **Member:** 1) Partner with Clarity Health Clinics to ensure Home State Health members are targeted and treated in the Hannibal area – includes Marion, Ralls, Ralls, Monroe, Montgomery and Pike Counties. The MCHP also developed a fluoride varnish program, and initiated this project with Clarity school nurses. 2) Partner with Evolve Dental to attend Affinia sponsored health fairs. Contact members in advance to make appointments. 3) Evolve Dental will mail a letter and a toothbrush package to members visiting Emergency Departments for dental issues. 4) Beginning July 2106 existing eligible members received a Primary Care Dental (PCD) assignment. ID cards were mailed. **Providers:** 1) Provider Incentive for Care Gap Closure with Missouri Health Plus, which included the ADV Measure.	Totals	**1** Met ____Partially Met _____Not Met _____UTD
Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	This analysis was based on the elements presented in the prospective data analysis plan.

This Element is "Not Met" if study is complete and there is no indication of a data analysis plan (see step 6.5)		
8.2 Were the PIP results and findings presented accurately and clearly?	X Met ___Partially Met __Not Met __Not Applicable __Unable to Determine	The tables included presented the results of the HEDIS like data for HY 2014, and actual HEDIS data for HY 2015, HY 2016 and HY 2017. These were presented clearly. All tables and graphs are easy to interpret. The accompanying narrative explains all results.
Are tables and figures labeled? xx yes __no Are they labeled clearly & accurately? xx yes ___no		The information presented included graphs and tables representing the increased HP population.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	X Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The results and the repeat measurements are presented. Home State Health provided some analysis of the data, which indicates a rate decrease in the past 2 years (CY 2015 and 2016). They did an analysis of their increased population, and how both the numerators and denominators increased each year. This analysis looks at each intervention and provides Home State Health's hypothesis about what interventions; together with some adjustment, it will create positive changes in the future. Home State Health also provided information on the factors that have negatively impacted the success of the interventions. The MCHP provides a sound argument for maintaining their commitment to some of the interventions in place, and the need to adjust others to yield more success.
Indicate the time periods of measurements: Monthly and Annually Indicate statistical analysis used: Chi-square Indicate statistical significance level or confidence level if available/known: _____99% __xx__95% ___Unable to determine		
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and any follow-up activities?	X Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The decline in the HEDIS rate is attributed to a combination of complex issues that are delineated in the narrative. The impact of the individual interventions is discussed. Home State Health plans to continue the infrastructure interventions. However, the MCHP will assess the use of more direct, "member-facing" interventions (education and informational materials intended to increase engagement in wellness behavior); interventions focused on closing care gaps by provider involvement; and direct member outreach.

Limitations described: _Addressed in detail. Conclusions regarding the success of the interpretation: Reasons for the lack of success for CY 2015 and 2016 are discussed Recommendations for follow-up: Changes to MCHP interventions are discussed.	Totals	__**4**__Met ___Partially Met _____Not Met __ Not Applicable _____UTD
Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	__**X**__Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The same sources of data were used throughout all measurements, and they utilized the same systems to collect data, the same participants, and similar measurement tools.
Ask: Were the same sources of data used? Did they use the same method of data collection? Were the same participants examined? Did they utilize the same measurement tools?		
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	__**X**__Met __Partially Met __Not Met __Not Applicable __Unable to Determine	Home State Health experienced a decline in their HEDIS ADV rate for 2 consecutive years. The MCHP provided a detailed and thoughtful analysis of why this occurred, and the changes that are needed to turn this trend around.
Was there: _____ Increase __xx__Decrease Statistical significance __xx__yes ___no Clinical significance ____yes __xx__no		
9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	__Met __Partially Met __Not Met __**X**__Not Applicable __Unable to Determine	Due to 2 years declining ADV rates, and the changes Home State Health put in place, there is not enough information to evaluate this project for "face" validity.
Degree to which the intervention was the reason for change ___No relevance ____Small ____ Fair ____High		

9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	Statistical testing was completed, but no positive results were experienced in the aggregate numbers.
_____Weak _____Moderate _____Strong	Totals	**2** Met _____Partially Met _____Not Met **2** Not Applicable _____UTD
Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	__ Met __ Partially Met __Not Met **X** Not Applicable __ Unable to Determine	Home State Health witnessed a decrease in the past two years in their aggregate ADV rates. They have committed to creating and supporting long-term projects that will positively impact member behavior, and include providers in developing solutions to this problem.
	Total	_____Met _____Partially Met _____Not Met **1** Not Applicable _____UTD
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	Comments
Were the initial study findings verified upon repeat measurement?		

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.

Conclusions: Home State Health presented a well-developed PIP. The data analysis, planning, and outcomes are documented. Due to lack of success of the interventions employed, the MCHP is committed to create long-term projects that will have the desired outcomes.

Recommendations:

1) Continue to use the type of explanation that accompanied the outcome data; as well as the MCHP's evaluation of what is/is not working. In each section analyzation of the data was provided, but the narrative also included summaries that illustrated the outcomes, reasoning, and planned improvement. The summaries are very helpful in interpreting the MCHP's understanding of the results.
2) Include recommendations for next steps, as presented in this PIP.

Check one:

☐ High confidence in reported Plan PIP results **X** Confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible ☐ Unable to determine – the PIP is new and has produced no results

Conclusions

Quality of Care

Both the clinical and non-clinical PIPs focused on providing quality services to members. The choice to focus a clinical PIP on assisting members in obtaining immunizations will provide for quality healthcare. The goal of improving knowledge regarding establishment of a relationship with a PCP was directly focused on the best quality healthcare. Home State Health has allocated resources to create process improvement of these issues. Each PIP indicated growth in the improvement strategies focused on providing quality healthcare to members.

Access to Care

Both PIPs submitted by Home State Health addressed improved access to health. The clinical PIP will assist in reducing the barriers members encounter when attempting to have their children immunized. In the non-clinical PIP, efforts were made to incentivize providers to assist members in having access to dental care. The MCHP developed a member incentive program to increase utilization of dental benefits through on-site dental clinics. They implemented new strategies that bring dental care directly to the members and their communities, thereby making care truly accessible in rural areas. The attention paid to reminding members of available resources enhances member access and directly impacts outcomes. The MCHP's efforts were fresh and had a clear goal of improving access to care. Although all outcomes did not reflect the anticipated improvements, Home State Health analyzed these problems and included next steps, which will continue to enable members to have access.

Timeliness of Care

Both projects addressed timely and adequate care. The clinical PIP focused on providing required immunizations for all eligible members. Strategies employed improved the opportunities of members obtaining immunizations by age 2. Home State Health has made a serious effort to identify problem areas for members and find solutions that best meet the members' needs. In the non-clinical PIP, there was attention to assisting the members to recognize their need to identify a provider and obtain the oral health care available. They initiated the primary care dental (PCD) program to provide a dentist to eligible members, so they have their own provider enabling them to obtain necessary appointments. The MCHP's efforts are focused on incentivizing providers and engaging community health providers, such as the FQHC's, to provide members timely access to dental services.

RECOMMENDATIONS

1. Explore operational and service issues identified by the MCHP and assess them for future PIP studies. The QI staff should be aware of these observations for program improvement.
2. Request technical assistance from the EQRO, as needed, in PIP development.
3. Expand narrative PIP sections to explain the MCHP's intentions, activities and outcomes.
4. Continue development of community healthcare collaboratives to ensure that members receive reminders from their dental providers, and have access to more providers.
5. Analyze interventions that did not produce expected outcomes and evaluate what was and was not effective.

   Look at potential success, and evaluate what might cause members to change their behavior. Home State Health PIPs have recognized that sending mailers did not have the impact hoped for. Before repeating interventions that were not effective, evaluate new interventions for their potential to produce desired results, before investing time and money:
6. Continue involvement with the Statewide PIP planning group. Home State Health has become an integral part of this group. Continued commitment to this group is an important aspect of an evolving improvement process.

7.2 Validation of Performance Measures

Methods

This section describes the documents, data, and persons interviewed for the Validating Performance Measures Protocol for Home State Health. Home State Health submitted the requested documents on or before the due date of March 7, 2017. The EQRO reviewed documentation between March 7, 2017 and June 21, 2017. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation. The MCHP could provide corrected data to ensure the calculation of all measures, this data was received by the EQRO on November 6, 2017, and the information contained in this section reflects the revised data.

Document Review

The following are the documents reviewed by the EQRO:

- NCQA RoadMap for the HEDIS 2016 data reporting year;
- HealthcareData.com LLC's Compliance Audit Report for HEDIS 2016;
- Policies and procedures about calculation of HEDIS 2016 rates;
- Meeting minutes on information system (IS) policies;
- A sample of Catalyst's production logs and run controls;
- National Council on Quality Assurance (NCQA)-certified HEDIS software certification report from Catalyst Technologies;
- Data field definitions & claims file requirements of the Corporate Data Warehouse;
- Data files containing the eligible population, numerators and denominators for each of the three measures; and
- HEDIS 2016 Data Submission Tool.

Data files were submitted by Home State Health for review by the EQRO; and these included statewide and regional files for PPC and files for EDV and EDU performance measures.

INTERVIEWS

The EQRO conducted on-site interviews at Home State Health in St. Louis on Wednesday, June 21, 2017 with staff responsible for calculating the HEDIS 2016 performance measures and the Measures Reported to MO HealthNet for the Data Year 2015. The objective of the visit was to verify the methods and processes behind the calculation of the HEDIS 2016 performance measures, and the measures reported to MO HealthNet in the Healthcare Data Quality Template report.

FINDINGS

Two of the measures being reviewed (Emergency Department Visits and Emergency Department Utilization) were calculated using the Administrative method; and the third measure (Prenatal and Postpartum Care) was calculated using the Hybrid method.

The reported PPC rate was 74.64% for the Prenatal rate and 61.61% for the Postpartum rate; both rates were lower than the statewide rate for all MCHPs (78.17% Prenatal and 62.73% Postpartum). This is the first year that the PPC measure has been audited by the EQRO since 2006; and the first year that it has been audited for Home State Health.

This was the second year that the EQRO was requested to validate the information provided by the MCHPs on the Healthcare Data Quality Template. The measures that the EQRO validated from this report were Emergency Department Visits (EDV) and Emergency Department Utilization (EDU). Both measures are stratified by presenting diagnosis (Behavioral Health; Medical; or Substance Abuse). These are modified from the 2016 HEDIS Technical Specifications for Ambulatory Care (AMB), Mental Health Utilization (MPT), and Identification of Alcohol and Other Drug Services (IAD).

MO HealthNet requested the EQRO recalculate these measures and compare the calculations to the data submitted on the Healthcare Data Quality Template. The objectives included determining if each MCHP was calculating the measure in the same fashion, and determining if the MCHP could reproduce and provide the data used to calculate these modified HEDIS measures. The EQRO was unable to validate either the EDV or EDU measure calculations for Home State Health. The data provided to the EQRO were recalculated and the same results were not obtained as reported to MO HealthNet.

Data Integration and Control

The information systems management policies and procedures for rate calculation were evaluated and were consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing, and reporting. For all three measures, Home State Health was found to meet all the criteria for producing complete and accurate data. There were no biases or errors found in the way Home State Health transferred data into the repository used for calculating the 2016 measures.

Documentation of Data and Processes

Although Home State Health uses a proprietary software package to calculate HEDIS measure rates, adequate documentation of this software and its processes was provided to the EQRO for review. The data and processes used for the calculation of measures were acceptable for the HEDIS measure PPC. However, the data and processes used for calculation of the two non-HEDIS measures are uncertain; and because the EQRO was unable to reproduce the numbers reported by Home State Health to MO HealthNet for these measures, the EQRO cannot find that Home State Health met all criteria applied for all three measures.

Processes Used to Produce Denominators

Home State Health substantially met all criteria for the processes employed to produce the denominators of the performance measures validated. This involves the selection of eligible members for the services being measured.

Processes Used to Produce Numerators

Two of the three measures were calculated using the Administrative method (EDV and EDU); and the third measure (PPC) was calculated using the Hybrid method. All measures included the appropriate data ranges for the qualifying events (e.g. service dates, delivery dates) as specified by the HEDIS 2016 Technical Specifications and the Healthcare Data Quality Template. Appropriate procedures were followed for the sampling of records for medical record reviews.

However, Home State Health supplied the same numbers for the EDV measures (a count of total ED visits) as it did for the EDU measures (a count of each member who made an ED visit) on the Healthcare Data Quality Template report. These numbers were not able to be reproduced and the EQRO must find their submission to be invalid.

For the 2016 review, Home State Health supplied an enrollment file that contained 328,359 lines of data of those lines of data, and the EQRO found 119,602 unique members. However, the data supplied by Home State Health to MO HealthNet listed a total eligible population of 114,706. Home State Health supplied a numerator file that contained a total of 81,121 EDV-Medical hits. However, Home State Health reported 81,165 hits to MO HealthNet for the EDV-Medical measure. This is a slight underestimate of 0.05%.

For the EDV-Behavioral Health measure, Home State Health supplied the EQRO with a numerator file that contained a total of 17 records. The EQRO validated those 17 records, but was not supplied with any additional data for this measure by the MCHP. Home State reported 771 hits to MO HealthNet for the EDV-Behavioral Health measure. Therefore, the EQRO found an overestimate of 0.78%. The EQRO is certain that the data provided by Home State cannot be used to produce the hits reported to MO HealthNet. The EQRO believes that the MCHP would benefit from a discussion with the EQRO about what data are expected.

For the 2016 review, Home State Health supplied the EQRO with a numerator file that contained a total of 593 records for the EDV-Substance Abuse measure. The EQRO validated 590 records, as three of those records contained an ED Place of Service Code of 22 and was not valid. Home State Health reported 190 hits to MO HealthNet for this measure. Therefore, an underestimate of 0.41% was found for the 2016 review; and the EQRO believes that Home State did not provide the same data in response to the EQRO's data request as it did to MO HealthNet. Additionally, Home State Health supplied the same numbers for the EDV measures (a count of total ED visits) as it did for the EDU measures (a count of each member who made an ED visit) on the Healthcare Data Quality Template report.

For the 2016 review, Home State Health supplied a total of 81,133 records for the EDU measures. Of those, 30,149 were found to be EDU-Medical hits. Home State reported 81,165 EDU-Medical hits to MO HealthNet. This is a difference of 51,016 hits and an overestimate of 52.62%. This is a much wider discrepancy than what was observed in 2015 when a difference of 246 hits and an underestimate of 0.33% was observed. However, for the 2016 report, the EQRO is certain that the data submissions received by the EQRO and the report submitted to MO HealthNet were inaccurate. Home State Health supplied the same numbers for the EDV

measures (a count of total ED visits) as it did for the EDU measures (a count of each member who made an ED visit) on the Healthcare Data Quality Template report.

For the EDU-Behavioral Health visits measure, Home State Health provided a file that contained only 17 records, and the EQRO validated all 17 records. However, Home State Health reported 771 EDU-Behavioral Health hits to MO HealthNet. This difference of 754 records is an overestimate of 0.78%. This is comparable to the 2015 findings for the EDU-behavioral health measure. The 2016 overestimate is directly attributable to an incorrect data submission to the EQRO.

The EQRO is certain that the data submissions received from Home State Health and the report submitted to MO HealthNet were both inaccurate. Home State Health reported 190 EDU-Substance Abuse hits, and the EQRO validated 590 hits in the file received. This is due to Home State Health supplying the same numbers for the EDV measures (a count of total ED visits) as it did for the EDU measures (a count of each member who made an ED visit) on the Healthcare Data Quality Template report. Therefore, the EQRO must find their submission to be invalid.

Sampling Procedures for Hybrid Methods

The Hybrid Method was used for the Prenatal and Postpartum measure: CMS Protocol Attachment XII, and Impact of Medical Record Review Findings and Attachment XV. Sampling Validation Findings were completed for this measure. Home State Health was compliant with all specifications for sampling processes.

Submission of Measures to the State

Home State Health submitted the Data Submission Tool (DST) for the HEDIS measure to the SPHA (the Missouri Department of Health and Senior Services) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and MO HealthNet Quality Improvement Strategy. Home State Health submitted data as requested for the Healthcare Data Quality Template.

Determination of Validation Findings and Calculation of Bias

As is shown in Table 26, no bias was found for the PPC measure; however, bias was observed in both the EDV and EDU measures.

Table 26 - Estimate of Bias in Reporting of Home State Health HEDIS 2015 and 2016 Measures.

Measure	Estimate of Bias 2015	Direction of Estimate	Estimate of Bias 2016	Direction of Estimate
Prenatal and Postpartum Care (PPC)	Measure Not Validated	N/A	No Bias	N/A
Emergency Department Visits - Medical	69.69%	Underestimate	0.05%	Overestimate
Emergency Department Visits – Behavioral Health	0.61%	Overestimate	0.78%	Overestimate
Emergency Department Visits – Substance Abuse	0.04%	Underestimate	0.41%	Underestimate
Emergency Department Utilization - Medical	0.33%	Overestimate	42.01%	Overestimate
Emergency Department Utilization – Behavioral Health	0.47%	Underestimate	0.78%	Overestimate
Emergency Department Utilization – Substance Abuse	0.06%	Overestimate	0.41%	Underestimate

Source: BHC, Inc., 2015 and 2016 External Quality Review Performance Measure Validation.

Final Audit Rating

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure (See Table 27). The rate for the Prenatal and Postpartum Care measure showed no bias and was therefore deemed Fully Compliant. The Emergency Department Utilization measure was found to be both under and overestimated, with the Medical visit measure having a bias of 42.01%; this measure was found to be Not Valid. Although, the Emergency Department Visits measure fell within 1% of the hits reported, the numbers reported in the Healthcare Data Quality Template were the same for both the EDV and EDU measure.

Table 27 - Final Audit Rating for Home State Health Performance Measures.

Measure	Final Audit Rating
Prenatal and Postpartum Care	Fully Compliant
Emergency Department Visits	Not Valid
Emergency Department Utilization	Not Valid

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCHP. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No Managed Care Members qualified for the measure.

CONCLUSIONS

Three rates were validated for the MCHP. The Prenatal and Postpartum Care rate was **lower** than the average for all MCHPs and the National Medicaid HMO HEDIS average; and the Emergency Department Visits measure and Emergency Department Utilization rates reported were **consistent** with the average for all MCHPs. However, these rates were unable to be validated by the EQRO.

QUALITY OF CARE

Home State Health's calculation of the Emergency Department Utilization measure was considered not valid as it did not comply with specifications. This measure serves to provide a count of the individual number of members who access the ED for various issues, over the course of the measurement year. This measure provides further detail to the reason for the ED visit, categorizing it as Medical; Behavioral Health or Substance Abuse. This information is useful to the MCHPs to determine if the ED is being utilized properly by its members.

Home State Health's rate for the EDU could not be validated due to the MCHP's errors in data submission.

ACCESS TO CARE

The Emergency Department Visit measure was rated as Not Valid, as the EQRO was unable to reproduce the count of services reported by Home State Health. Although not validated due to submission errors, Home State Health's rate for the EDV- Medical measure was consistent with the average for all MCHPs, indicating that Home State Health's members are accessing the ED for Medical issues at a rate similar to that of the other MCHPs. Home State Health's reported

rate for the EDV- Substance Abuse measure was higher than the average for all MCHPs, indicating that Home State Health's members are accessing the ED for Substance Abuse issues more than that of the other MCHPs.

TIMELINESS OF CARE

Home State Health's calculation of the HEDIS 2016 Prenatal and Postpartum Care measure was fully compliant. This measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received. The MCHP's reported rate for this measure was **lower** than the average for all MCHPs and the National Medicaid HMO Average. This rate was previously audited by the EQRO in 2006, prior to the Home State Health's contracting with MO HealthNet.

Home State Health members are receiving care in a less timely manner, for this measure, than that of other MO HealthNet Managed Care members. The MCHP's members are receiving Prenatal and Postpartum Care in a manner that is **less** timely than the average Medicaid member across the nation.

RECOMMENDATIONS

1. Continue to conduct and document statistical comparisons of rates from year to year.
2. Continue to participate in training of MCHP staff involved in the oversight of coordination of performance measure calculation.
3. Continue to perform hybrid measurement on those measures that are available for this method of calculation.
4. Provide information for data requests in the format and file requested. If questions arise, contact the EQRO for clarification.
5. Contact the EQRO for assistance when completing data requests.

7.3 MCHP Compliance with Managed Care Regulations

METHODS

Home State Health was subject to a follow-up compliance audit during this on-site review. The content of this 2016 calendar year audit will include follow-up to any components of the Quality Standards as defined in 42 CFR 438 that were found to be lacking during the 2015 review. Evaluation of these components included review of:

- Defined organizational structure with corresponding committee minutes
- Policies and Procedures
- Organizational protocols
- Print materials available to members and providers
- Report results
- Staff interviews

The Team utilized an administrative review tool which was developed based on the CMS Protocol Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations (Compliance Protocol). The evaluation included review of Home State Health's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, Home State Health was evaluated on the timeliness, access, and quality of care provided. This report incorporates a discussion of the MCHP's strengths and weaknesses with recommendations for improvement to enhance overall performance and compliance with standards.

The EQRO rating scale remains as it was during the last evaluation period.

M = Met

Documentation supports that all components were implemented, reviewed, revised, and/or further developed.

PM = Partially Met

Documentation supports some but not all components were present.

N = Not Met

No documentation found to substantiate this component.

N/A = Not Applicable.

Component is not applicable to the focus of the evaluation. N/A scores will be adjusted for the scoring denominators and numerators.

A summary for compliance for all evaluated Quality Standards is included in Table 28.

Table 28 - Home State Health Compliance Ratings for Compliance Review Years (2014-2016).

Measure	2014	2015	2016
Enrollee Rights and Protections	100%	100%	100%
Access and Availability	76.47%	76.47%	82.35%
Structure and Operations	100%	100%	100%
Measurement and Improvement	100%	81.82%	81.82%
Grievance Systems	100%	100%	100%

Source: BHC, Inc., 2014-2016 External Quality Review Compliance Validation.

The review of Quality Standards was completed using a Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

FINDINGS

Enrollee Rights and Protections

Enrollee Rights and Protections address 13 standards. For the 2016 review, Home State Health was rated by the review team to have met all 13 standards. This is an overall rating of 100% compliance and is consistent with this MCHP's 2014 and 2015 ratings. Home State Health has

participated in community-based programs throughout all three Managed Care regions and has been involved in school-based health clinics whenever possible. The MCHP participated in back-to-school fairs and other events throughout each region.

The rating for Enrollee Rights and Protections (100%) reflects that the MCHP complied with the submission and approval of all policy and procedures to MO HealthNet. All practice observed at the on-site review indicated that the MCHP appears to be fully compliant with Medicaid Managed Care Contract requirements and federal regulations in this area.

Access Standards

Access and Availability addresses 17 standards. For the 2016 review, Home State Health was rated by the review team to have met 14 standards. This is an overall rating of 82.35%; and this is **higher** than the 76.47% rating received in 2014 and 2015. Although Home State Health improved in Case Management, their low rating in the Availability of Services Provider Network category impacted the lack of increase in the Access and Availability standards overall.
The MCHP identified persons for case management, provided referrals, involved PCPs; and improved their processes for documenting the case management services being delivered to members. Home State Health submitted required policy and procedures to MO HealthNet for their approval. However, in reviewing records and interviewing case management staff, full evidence of comprehensive assessments and member involvement in treatment planning was not available. The area of primary care coordination was improved over the 2015 rating.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2016 review, Home State Health was rated by the review team to have met all 10 standards. The rating for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the fourth year. The MCHP submitted all required policy for approval, and all practice observed at the time of the on-site review indicated compliance in this area. All credentialing policy and practice was in place. All disenrollment policy was complete; and all subcontractor requirements were met.

Home State Health is NCQA accreditation and follows NCQA standards regarding credentialing. All credentialing performed by Home State Health meets NCQA standards and

complies with federal and state regulations, and MO HealthNet contract requirements. Re-credentialing is completed at three-year intervals, and delegated entities are monitored annually. State and federal sanctions are monitored monthly using the HHS OIG/OPM (Office of Inspector General/Office of Personnel Management) web site.

Measurement and Improvement

The area of Measurement and Improvement addresses 12 standards. Home State Health was rated by the review team to have met 9 standards and partially met two standards; and one standard was found to be Not Applicable. This is an overall rating of 81.82% and is **consistent** with their 2015 rating; but is **lower** than their 2014 rate of 100% compliance.

The MCHP submitted three Performance Measures (PMs) for validation, and one of these PMs received a Fully Compliant rating; the other two were found to be Not Valid. The MCHP also submitted two Performance Improvement Projects (PIPs), the non-clinical PIP received a rating of 100% compliance. The clinical PIP received a rating of 81.82% due to some problems with data analysis and reporting. The specific details can be found in the appropriate sections of this report.

Grievance Systems

Grievance Systems address 18 standards. For the 2016 review, Home State Health was found to have met all 18 standards. This is an overall rating of 100% compliance and is consistent with the ratings received in 2014 and 2015. Ratings for compliance with the Grievance Systems regulations (100%) indicate that the MCHP completed all requirements regarding policy and practice.

CONCLUSIONS

Home State Health was compliant in all areas of policy, procedure, and practice required by the Managed Care contract and the federal regulations. The MCHP utilizes a proactive approach to identifying issues, internal monitoring, and its Quality Improvement program to ensure that required written materials were submitted to MO HealthNet in a timely and efficient manner.

The staff at Home State Health exhibits a commitment to quality and integrity in their work with members. Home State Health has created tools to educate and inform the community and providers.

Issues were identified during this year's review with the lack of member input in treatment plans and less than comprehensive assessments from Case Management files. However, the MCHP improved in the areas of appropriately introducing members to case management and providing face-to-face contacts.

Quality of Care

Quality of care is a priority for Home State Health. Their attention to internal and external problem solving, supporting and monitoring providers, and participation in community initiatives are evidence of the commitment to quality healthcare. They are making a concerted effort to extend this approach to all three MO HealthNet regions. Home State Health completed all policy requirements and has put processes in place to ensure that procedures and practices follow approved policy requirements.

However, missing comprehensive assessments and lack of member input into treatment plans in Case Management files indicate that an improvement can be made in this area to ensure that the evidence exists to support that the quality of care received by members in Case Management matches those delivered in other areas of the organization.

Access to Care

Home State Health has made concerted efforts to ensure that members throughout their MO HealthNet regions have adequate access to care. The MCHP has participated in community events to promote preventive care and to ensure that members are aware of available services. The MCHP exhibits an awareness and commitment to resolving issues that are barriers to member services.

Although Home State Health made some improvement in Case Management, their low rating in the Availability of Services: Provider Network category impacted the lack of increase in the Access and Availability standards overall.

Timeliness of Care

Home State Health has developed procedures to ensure that policy is submitted in a timely manner, and that all tracking tools are up-to-date. They are utilizing case management software and systems tools to have the most accurate and up-to-date information available on members to support them in obtaining appropriate healthcare services in a timely manner. The MCHP has engaged in activities to ensure that organizational processes support the delivery of timely and quality healthcare.

Recommendations

1. Make every effort to supply the EQRO with all relevant information for every case file, grievance file, policy, or procedure requested.
2. Make every effort to be involved in the community and to cultivate resources to help staff perform their job functions to the fullest potential.
3. Supply training regarding contract requirements to the Case Management staff to ensure compliance with all timelines and content standards.
4. Continue monitoring access to dental care and assist in recruitment of providers throughout all Regions.
5. Continue to monitor provider and hospital networks for adequacy. Develop contracts where possible.
6. Maintain an updated provider website with accurate information regarding provider availability.
7. Provide the EQRO with data as requested for validation. If questions or concerns arise as to the data, contact the EQRO for assistance.

8.0 Missouri Care Health Plan

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8.1 Performance Improvement Projects

Document Review

Missouri Care supplied the following documentation for review:

- Improving Childhood Immunizations
- Improving Oral Health

Interviews

Interviews were conducted with the following MCHP project leaders for each Performance Improvement Project (PIP) by the EQRO team on June 27, 2017, during the on-site review:

- Mark Kapp, Senior Manager, Quality Improvement
- Vicki Mertz, Quality Improvement Project Manager
- Erin Dinkel, Manager, Quality Improvement
- Karen Einspahr, Quality Improvement Analyst

The interviewees shared information on the validation methods, study design, and findings of the PIPs. Technical assistance regarding new study development, study design, and presentation of findings was provided by the EQRO. The following questions were addressed:

- How were the outcomes interpreted and linked to the interventions?
- How were the interventions determined and why did the MCHP choose this approach?
- Discuss the effects of these interventions and how they impacted services to members.
- How are the PIP interventions and goals communicated throughout Missouri Care? Are all staff, including case managers and customer services personnel, involved?

The MCHP was given the opportunity to submit updates to the outcomes of the interventions and additional data analysis. The information evaluated here is based on the enhanced submissions and additional data that were supplied.

FINDINGS

CLINICAL PIP – CHILDHOOD IMMUNIZATION STATUS

Missouri Care's clinical PIP focused on improving the number of children who receive the immunizations required in HEDIS Combo 3, by their second birthday. This PIP was implemented in 2015, with calendar year 2014 considered the baseline year. The MCHP intends to provide its members a healthy start to life based on helping them obtain the Centers for Disease Control and Prevention's (CDC) recommended immunizations for children, which is the best protection against preventable diseases.

The MCHP chose a multi-faceted approach to ensure that members and providers were both engaged in improving services to members. Interventions implemented, according to the PIP submission, during 2016 included:

Member Interventions:

- Provide incentives to members who complete their well-child visits. (A 2015 intervention – not enhanced or changed in 2016).

Provider Interventions:

- Incentives to providers to encourage them to provide required Childhood Immunizations.

Plan Interventions:

- Provider Flat-file Transfer – scraping immunization data directly from providers' Electronic Medical Records (EMR) system into WellCare's database. (Used in four provider groups).

The HEDIS rates did not improve. The HEDIS Year 2016 rate was 64.22%, while the HEDIS Year 2017 declined to 56.02%. This is also a decline from the baseline year, HEDIS Year 2015, a rate of 62.72%. The MCHP insists that their multi-interventional approach, to ensure that rates sustain or improve through member and provider engagement, is the most effective approach to change. Missouri Care identified the following barriers to accomplishing their goal for this PIP. They include:

Member Barriers:

- The belief that:
    - Vaccinations are the cause of autism;
    - Children can build immunity naturally; and
    - Vaccines expose children to toxins.
- Parents prefer to spread out the doses instead of getting them all at once - thus a child receives their last dose past 24 months.
- Fear of side effects.
- Parents find it difficult to take time off from work to keep child's vaccination appointment
- Transportation.

Provider barriers:

- Lack of provider education on clinical guidelines adopted by Missouri Care.

Plan barriers:

- Inability to contact member related to frequent moves, change of phone number, etc.

Missouri Care intends to continue the successful interventions in the upcoming year while developing new interventions to continually improve members' overall health and the CIS-Combo 3 rates. The MCHP will continue to measure the impact of this PIP on an ongoing basis, which will be accomplished by tracking and trending for significant increases in indicator rates over time. A Plan-Do-Study-Act cycle of continuous process improvement is used to monitor note, to implement changes, and to test the effectiveness of changes made throughout the year. Modifications can occur in a timely fashion when they are identified. Missouri Care has developed new interventions to continually improve members' overall health and the CIS-Combo 3 rate.

The following Validation Worksheet provides the details of how the project met each PIP requirement:

Demographic Information		
Plan Name or ID: Missouri Care Health Plan		
Name of PIP: Childhood Immunization Status		
Dates in Study Period: July 2015 - Present		
I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
Step 1: REVIEW THE SELECTED STUDY TOPIC(S)		
Component/Standard	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	___Met __X__ Partially Met __ Not Met __ Unable to Determine	The PIP presents a convincing argument regarding the need for children to receive appropriate immunizations. The discussion did not include how Missouri Care related their current performance to the decision to implement a PIP focused on improving the number of children receiving needed immunizations. The topic presentation pointed out the need to improve Missouri Care's CIS HEDIS rate. The MCHP is not reaching the 90th percentile in numbers of children properly vaccinated. It also talks about Missouri children enrolled in child care who failed to get immunized. No information is provided regarding the Missouri Care's current rates, and what the goals for improvement are. The presentation does not truly link the decision to develop this PIP to issues within the Missouri Care population.
Clinical __xx__ Prevention of an acute or chronic condition ____ High volume services ____ Care for an acute or chronic condition ____ High risk conditions		
Non-Clinical ___Process of accessing or delivering care		
1.2 Did the Plan's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	___Met __X__ Partially Met __Not Met __Unable to Determine	The narrative states that Missouri Care designed this PIP to improve the number of children receiving immunizations and that this is an important aspect of preventive care. The reason that this is important to Missouri Care members, other than improving MCHP HEDIS rates, is vague.
Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.		
1.3 Did the Plan's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	__X__ Met __Partially Met __Not Met __Unable to Determine	The narrative states that the PIP will include all Missouri Care members who reach 2 years of age in the measurement year. This does not exclude any MCHP member who should be part of this population.
Demographics: __xx Age__ Range _____Race _____Gender Medical Population: __xx__ Medicaid Only _____ Commercial	Totals	__1__ Met __2__ Partially Met _____Not Met _____UTD

Step 2: REVIEW THE STUDY QUESTION(S)		
2.1 Was the study question(s) stated clearly in writing?	___Met **X** Partially Met __ Not Met __Unable to Determine	The narrative explaining the question includes the fact that they will implement member education interventions; and interventions to increase the percentage of members receiving the stated immunizations. Missouri Care wants to improve their HEDIS rates for Combo 3 and Combo 10. The current percentage of children/members receiving immunizations within Missouri Care is not mentioned. It does talk about the goal to increase CIS HEDIS by 3% for each measurement year. Is the 90% a long term or short-term goal? How far is the MCHP from achieving this goal?
Include study question(s) as stated in narrative: "Will the implementation of member education and interventions be successful at increasing the percentage of Missouri Care members who receive 4 DTaP; 3 IPV; 1 MMR; 3 HiB; 3 HepB; 1 VZV; 4PCV; 1 HepA; 2 or 3 RV; and 2 flu vaccines by their second birthday? Success will be measured by reaching a target rate of 90% per RFP contract."	Total	This study question defines CIS Combo 10, and does not delineate the immunizations required for Combo 3, which is the focus of the PIP. _____ Met **_1_** Partially Met _____Not Met _____UTD
Step 3: Review Selected Indicators		
3.1 Did the study use objective, clearly defined, measurable indicators?	**X** Met ___Partially Met __ Not Met __ Unable to Determine	The study calls out the use of their HEDIS rate for Combo 3 anndCombo-10. The numerators and denominators are defined.
List Indicators: The Study indicator came from the CIS-Combo 3 and 10 measure in the HEDIS Technical Specifications.		
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	**X** Met ___Partially Met __ Not Met __ Unable to Determine	The indicators do measure an improvement in children's health by obtaining required immunizations.

Are long-term outcomes implied or stated: _xx_ yes __no _xx Health_ Status _____Functional Status _____Member Satisfaction _____Provider Satisfaction	Totals	_**2**_Met ____ Partially Met _____Not Met _____UTD
Component/Standard	**Score**	**Comments**
Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did the Plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	_**X**_ Met __ Partially Met __ Not Met __ Unable to Determine	The focus of the PIP is treating all members up to 2 years of age in the measurement year. It also says that the PIP aligns with the current HEDIS 2017 Technical Specifications.
Demographics _0 – 2_ Age Range _____Gender _____Race Medical Population: __xx__Medicaid Only _____Commercial		
4.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?	_**X**_ Met ___Partially Met __ Not Met __ Unable to Determine	The data collection approach utilized to produce CIS HEDIS rates is designed to capture all eligible members.
Methods of identifying participants: _____Utilization data _____Referral _____Self-identification _____Other _____	Totals	_**2**_Met ___ Partially Met _____Not Met _____UTD
Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	__Met __Partially Met __Not Met __Unable to Determine	These is no sampling used in this PIP
Previous findings from any other source: ___literature review ___baseline assessment of indices ___other		
5.2 Were valid sampling techniques that protected against bias employed?	__Met __Partially Met __Not Met __Unable to Determine	

Specify the type of sampling or census used:		
5.3 Did the sample contain a sufficient number of enrollees?	__Met __Partially Met __Not Met __Unable to Determine	
_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	Totals	__NA__Met ____Partially Met ____Not Met _____UTD
Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	**X** Met __Partially Met __Not Met __Unable to Determine	The PIP narrative explains that they will review the claims data pertaining to CIS-Combo 3 and 10. Missouri Care also uses the Hybrid Methodology to support and enhance their HEDIS results. This information will be used to determine if the interventions employed have been effective. The HEDIS Tech Specs pertaining to HEDIS Childhood Immunization Status (includes Combo 3 and Combo 10) will be used to ensure data reliability.
6.2 Did the study design clearly specify the sources of data?	**X** Met __Partially Met __Not Met __Unable to Determine	The sources of the data are claims submissions extracted using the NCQA certified software. All codes that identified Childhood Immunizations used to identify necessary vaccinations are included. The requirements and methods to complete the Hybrid medical records review were included.
Sources of data: ___Member __xx__ Claims ___Provider __xx__ Other: Hybrid Data		
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	**X** Met __Partially Met __Not Met __Unable to Determine	The study design does provide a detailed explanation of all aspects of the data collection process. Because the HEDIS Tech Specs are the foundation for this methodology, it is believed that the data is collected in a valid and reliable manner.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	**X Met** __Partially Met __Not Met __Unable to Determine	The use of a specific software vendor (Involan), and a certified vendor to complete the medical record information extraction (Altegra) provides confidence that data collection will occur in a consistent and accurate manner over the time that the PIP is active.
Instruments used: ____Survey __xx__Medical Record Abstraction Tool Other: _____		Inclusion of a description of how medical records are accessed for the hybrid evaluation was submitted.

6.5 Did the study design prospectively specify a data analysis plan?	**X** Met __Partially Met __Not Met __Unable to Determine	A detailed prospective data analysis plan is provided. All aspects of data analysis are included. The plan specifies that they will use a HEDIS-like methodology which will enable them to obtain quarterly rates to monitor the ongoing outcomes of the interventions in place.
6.6 Were qualified staff and personnel used to collect the data?	**X** Met __Partially Met __Not Met __Unable to Determine	The staff are all included. Their qualifications and assignments for this PIP are provided.
Project Leader Name: Vick Mertz, MA Title: QI Project Manager Role: Oversight of the PIP process and data collection. Other team members: Names/Roles: Supporting personal, their roles and responsibilities are all included.	Totals	**6** Met _____Partially Met _____Not Met _____UTD
Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	___Met **X** Partially Met ___Not Met __Unable to Determine	Missouri Care initiated one revised intervention for providers. The only member-focused intervention started in 2015. Other interventions were ongoing or began in 2014. The MCHP must specify revised or enhanced interventions for each study year. Interventions can be included as "ongoing." Each study year must include measurable interventions. The method for including interventions is somewhat confusing. For example, a 2014 "Member Engagement" intervention is using MOHSAIC data quarterly. This is a strategy to use an information source from the State. It is not a method or intervention to engage members in obtaining their children's immunizations. The study question asks, "Will the implementation of member education and interventions …." To answer this question, member focused education and interventions should be employed. This is a clinical PIP, so that interventions should address methods to directly improve member services.
Describe Intervention(s): **Member**: 1) Provide incentives to members who complete their well-child visits. (A 2015 intervention – not enhanced or changed in 2016). **Providers**: 1) Incentives to providers to encourage them to provide required childhood Immunizations	Totals	____Met **1** Partially Met _____ Not Met _____UTD

Plan: 1) Provider Flat-file Transfer – scraping immunization data directly from providers' EMR system into WellCare's database. (Used in 4 provider groups). (This is a strategy for improving HEDIS rates – not an intervention that enhances or improves member services)		
Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The data analysis did follow the prospective plan, in terms of providing a comparison of the HEDIS data from the baseline year – HEDIS 2015/CY 2014 to follow-up years (HEDIS Year 2016 and 2017).
This Element is "Not Met" if study is complete and there is no indication of a data analysis plan (see step 6.5)		
8.2 Were the PIP results and findings presented accurately and clearly?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The results, in both tables and graphs were presented clearly and accurately. The tables breaking down the numerical results also contain information about the statistical evidence regarding the improvement/decline in HEDIS rates. The accompanying narrative was confusing. Each paragraph included Combo 3 and Combo 10 information. If both are reported, the discussion should include all information pertaining to Combo 3, with a separate discussion of Combo 10 results. All information was presented, but was difficult to interpret.
Are tables and figures labeled? xx yes __no Are they labeled clearly & accurately? xx yes ___no		
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	__ Met **X** Partially Met __ Not Met __Not Applicable __Unable to Determine	The analysis presented the baseline year (HY 2015), and two follow-up years (HY 2016 and 2017). Statistical significance was noted. However, factors that influenced the outcomes achieved are not identified. In one statement, Missouri Care reports that "no root cause was identified" when discussing the outcomes and lack of improvement. This does not answer the question.

		HY 2017 declined from a rate (HY 2016) of 64.22% to a current rate (HY 2017) of 56.02%.
Indicate the time periods of measurements: _____Yes_____ Indicate statistical analysis used: _Yes Indicate statistical significance level or confidence level if available/known: _____99% _xx 95% ___Unable to determine		Missouri Care notes that they will continue to monitor the effectiveness of its multi-interventional approach. There are no new or innovative interventions focused on member behavior. The narrative states that Missouri Care will continue to review the effectiveness of interventions. However, the HEDIS 2017 rate declined. There is no discussion about why the interventions employed were ineffective.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and any follow-up activities?	__ Met **X** Partially Met ___Not Met ___Not Applicable __Unable to Determine	There was some limited analysis of the outcomes. However, the presentation lacked discussion or interpretation of how the interventions in place contributed to the outcomes achieved. If this analysis occurred, it may provide insight into changes needed to the approach to create positive outcomes. The analysis states Missouri Care used "A Plan-Do-Study-Act cycle of continuous process improvement." Evidence of this method is not included. Narrative states that this "process will be used to plan and implement changes and guide the test of a change to determine if the change is an improvement." The discussion states that, in one region, two large provider groups were termed, resulting in members establishing care with new providers. It does not state what actual impact this had in that region or why. Follow-Up activities are presented. The narrative again espouses that the multi-interventional approach is used to ensure that rates are sustained or improved. There is no analysis about why they experienced a declining rate from HY 2016 to HY 2017.
Limitations described: **Barriers impacted by member engagement interventions:** The beliefs that: o Vaccinations are the cause of autism o Children can build immunity naturally o Vaccines expose children to toxins o Parents prefer to spread out the doses instead of getting them all at once – thus as a child receives	Totals	It should be noted that the "Flat-file Transfer" is a strategy for more accurately identifying data to improve the Missouri Care's HEDIS rate. It is not an intervention. The use of provider incentives need to be reflected in the study question.

their last dose past 24 months ○ Fear of side effects ○ Parents find it difficult to take time off from work to keep child's vaccination appointment ○ Transportation **Barriers for health plan include:** ○ Unable to contact member related to frequent moves, change of phone number, etc. **Barriers impacted by providers' engagement interventions:** ○ Lack of provider education on clinical guidelines adopted by Missouri Care **Recommendations for follow-up:** 1. Flat-file Transfer 2. Apply incentives to encourage providers to address recommended childhood immunizations **3.** Apply incentives to encourage adherence to recommended well-child visits		**2** Met **2** Partially Met ___ Not Met ____Not Applicable _____UTD
Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	**X** Met __ Partially Met __ Not Met __Not Applicable __Unable to Determine	The same methodology and tools have been used throughout the study. This is explained in the narrative and is evident in the data analysis presented.
Ask: Were the same sources of data used? Did the use the same method of data collection? Were the same participants examined? Did they utilize the same measurement tools?		
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	__ Met **X** Partially Met __ Not Met __Not Applicable __Unable to Determine	There was a lack of improvement in the aggregate outcomes for HY 2017. The narrative calls out that there was some improvement by region. There is very little analysis of why the differences occurred. Also, the narrative continually talks about both Combo 3 and Combo 10 results. This is confusing and makes it difficult to compare region to region or year to year results for Combo 3. Missouri Care asserts that there is no sufficient evidence to identify trends. However, the interventions in place have failed to meet MCHP goals for 2 years (even though HY 2016 did show improvement from HY 2015).
Was there: _xx_ Increase _xx_ Decrease Statistical significance: _xx_ yes _xx_ no Clinical significance: ___ yes ___ no		

9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	__Met __Partially Met __Not Met __X__ Not Applicable __Unable to Determine	There is no enough evidence now to accurately evaluate any outcomes achieved.
Degree to which the intervention was the reason for change ___No relevance ___Small ___ Fair ___High		
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	__ Met __ Partially Met __ Not Met __X__ Not Applicable __Unable to Determine	There is no enough evidence now to accurately evaluate any outcomes achieved.
_____Weak _____Moderate _____Strong	Totals	__1__Met __1__Partially Met _____Not Met __2 Not__ Applicable _____UTD
Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	__ Met __ Partially Met ___Not Met __X__ Not Applicable __ Unable to Determine	There is no enough evidence now to accurately evaluate any outcomes achieved.
	Total	_____Met _____Partially Met _____Not Met __1__Not Applicable _____UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	Comments
Were the initial study findings verified upon repeat measurement?		

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.

Conclusions:

Missouri Care has identified an area of service to members that does need improvement. The MCHP is currently providing appropriate immunizations to 56.02% of their members. The statewide goal and stated goal of this PIP are both 90%. This indicates an area where new and innovative interventions should be employed to achieve the stated goal.

Recommendations:

1) Assess current outcomes and what needs to change to achieve stated goals. Be specific;
2) Assess how each intervention contributed to these outcomes;
3) Develop interventions that are measurable, and that can be analyzed for either improving or declining results;
4) Evaluate the activities that will impact provider and member behavior, and develop interventions that are designed to meet these goals; and
5) When providing data analysis, include narrative about the meaning of the results achieved, and separate the results for Combo 3 from Combo 10. Try to provide data in a simple straightforward manner.

Check one:

☐ High confidence in reported Plan PIP results
☐ Moderate confidence in reported Plan PIP results
☐ Low confidence in reported Plan PIP results
☐ Reported Plan PIP results not credible
X Unable to determine – the PIP is new and has produced no results

NON-CLINICAL PIP – IMPROVING ORAL HEALTH

Missouri Care's individualized approach to the Statewide PIP "Improving Oral Health" has the goal to: Improve members' oral health outcomes through education and on-going interventions. The MCHP's research found that dental care is the most prevalent unmet health need among children. Access to dental services is an ongoing challenge for their members. The MCHP intends to improve its members' oral health outcomes through education and on-going interventions.

To achieve this goal new interventions were implemented during CY 2016 including:

Member Interventions:

- Maintaining a successful collaboration with DentaQuest to utilize the Smiling Stork program, for educational purposes.

Provider Interventions:

- Housing Authority Partnership – Partnering with local Housing Authorities to host Back to School and Health Fairs that will focus on providing dental screenings and education for participants.
- Partnership with Affinia – Missouri Care Community Outreach will collaborate, through their Dental Home Project, with Affinia Healthcare in the Eastern Region.
- Continued development of the dental home pilot project – Missouri Care designates a dental primary care provider and encourages the routine use of dental services.

Missouri Care supplied HEDIS rates for each region as well as the aggregate data. The MCHP achieved the goal of a 3% improvement for the calendar year 2014. The rates and data

presented indicate a statistically significant improvement over the previous year. The current HEDIS rates are the highest achieved by the MCHP.

The aggregate rates for the MCHP are:

- CY 2012 – 43.91%
- CY 2013 – 31.39%
- CY 2014 – 45.74%
- CY 2015 – 46.60%
- CY 2016 – 46.97%

Missouri Care concludes that the interventions in place are producing positive outcomes, so that they will continue. The MCHP rates are increasing. However, the improvement is only 1.23 percentage points in the last 2 years. This does not meet the goal of 3% per year, and leaves questions about the true effectiveness of the interventions that are in place. Missouri Care has achieved a 6.96% increase from CY 2012 (baseline year) to CY 2016. This does not meet their overall goal of a 12% improvement for this same period.

Missouri Care did provide a narrative about the outcomes achieved in all three regions and statewide. They assert that the initiatives that they have put in place are directly responsible for the improvement received, even though they did not achieve the 3% increase sought in CY 2016. The MCHP states that they will continue to monitor the effectiveness of current interventions, as well as assessing the outcomes of new interventions. New interventions for CY 2017 were presented. The narrative states, "An opportunity was identified for Case Managers to educate members that are actively engaged, on their annual dental benefits, as well as prevention." This opportunity is integrated in the HY 2018 interventions.

The following Validation Worksheet provides the details of how the project met each PIP requirement:

Demographic Information		
Plan Name or ID: Missouri Care		
Name of PIP: Improving Oral Health		
Dates in Study Period: January 2010 – Present (2/17)		
I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
Step 1: REVIEW THE SELECTED STUDY TOPIC(S)		
Component/Standard	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	**X** Met __ Partially Met __ Not Met __ Unable to Determine	The study topic presentation is well developed and provides a sound foundation for choosing this topic as a PIP. It relates the Missouri Care population to the national issues discussed.
Clinical ___Prevention of an acute or chronic condition ___High volume services ___Care for an acute or chronic condition ___High risk conditions		
Non-Clinical **xx** Process of accessing or delivering care		
1.2 Did the Plan's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	**X** Met __Partially Met __Not Met __Unable to Determine	The presentation includes information about the importance of dental care to good overall physical health. It does satisfy this requirement.
Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.		
1.3 Did the Plan's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	**X** Met __Partially Met __Not Met __Unable to Determine	All members between ages of 2-20 are included. There are no exclusions based on Special health care needs.
Demographics: 2-20 Age Range _____Race _____Gender Medical Population: **xx** Medicaid Only _____ Commercial	Totals	**3** Met _____Partially Met _____Not Met _____UTD

Step 2: REVIEW THE STUDY QUESTION(S)		
2.1 Was the study question(s) stated clearly in writing?	**X** Met __Partially Met __Not Met __Unable to Determine	The study question incorporates the focus of the current year's ADV PIP regarding improving oral health.
Include study question(s) as stated in narrative: "Will providing educational interventions concerning dental hygiene and the importance of annual preventive dental visits to Missouri Care members from the ages of 2 – 20 years old improves members' oral health and result in an increase in the HEDIS ADV rate of 3% for the measurement year.	Total	**1** Met ___Partially Met _____Not Met _____UTD
Step 3: Review Selected Indicators		
3.1 Did the study use objective, clearly defined, measurable indicators?	**X** Met __Partially Met __Not Met __Unable to Determine	Missouri Care will use the HEDIS ADV measure. The numerator and denominator, as defined by the HEDIS tech specs, are included. Additionally, the MCHP will use HEDIS-like data to evaluate the "data trends" on a quarterly basis.
List Indicators:		
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	**X** Met ___Partially Met __ Not Met __ Unable to Determine	The indicator used measures Missouri Care's performance in achieving improvement in the number of members age 2-20 who obtain annual dental visits. This addresses a process of care associated with improved health care delivered to members.
Are long-term outcomes implied or stated: **xx** yes _no _____Health Status _____Functional Status _____Member Satisfaction _____Provider Satisfaction	Totals	**2** Met ___Partially Met _____Not Met _____UTD
Component/Standard	**Score**	**Comments**

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did the Plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	**X** Met __ Partially Met __ Not Met __ Unable to Determine	The PIP explains that the entire Missouri Care population of ages 2-20 is included, and this is consistent with the HEDIS Tech Specs.
Demographics **2 - 20** Age Range _____Gender _____Race Medical Population **xx** Medicaid Only _____Commercial		
4.2 If the studied included the entire population, did its data collection approach capture all enrollees to whom the study question applied?	**X** Met __Partially Met __Not Met __Unable to Determine	The narrative explains how the entire population is identified using the methodology set out by HEDIS Tech Specs.
Methods of identifying participants: **xx** Utilization data _____Referral _____Self-identification _____Other _____	Totals	**2** Met ____Partially Met _____Not Met _____UTD
Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	__Met __Partially Met __Not Met __Unable to Determine	No sampling is used in the PIP.
Previous findings from any other source: ___literature review ___baseline assessment of indices ___other		
5.2 Were valid sampling techniques that protected against bias employed?	__Met __Partially Met __Not Met __Unable to Determine	
Specify the type of sampling or census used:		
5.3 Did the sample contain a sufficient number of enrollees?	__Met __Partially Met __Not Met __Unable to Determine	
_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	Totals	NA Met ____Partially Met ____Not Met _____UTD
Step 6: REVIEW DATA COLLECTION PROCEDURES		

6.1 Did the study design clearly specify the data to be collected?	**X** Met __Partially Met __Not Met __Unable to Determine	The explanation presented the information pertinent to HEDIS data collection. The study design and how it expects to impact members' healthcare are explained in the data analysis plan.
6.2 Did the study design clearly specify the sources of data?	**X** Met __Partially Met __Not Met __Unable to Determine	The sources of the data are claims and encounter data. The software to be used and how it functions are included.
Sources of data: ___Member **xx** Claims ___Provider _____ Other:		
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	**X** Met __Partially Met __Not Met __Unable to Determine	The narrative explains how the HEDIS processes are followed, and how this informs data are collected. The narrative described the NCQA certified software and how this ensures that valid and reliable data are collected.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	**X** Met __Partially Met __Not Met __Unable to Determine	The method and tools used throughout the PIP have remained consistent.
Instruments used: _____Survey _____Medical Record Abstraction Tool Other: _____		
6.5 Did the study design prospectively specify a data analysis plan?	**X** Met __Partially Met __Not Met __Unable to Determine	A data analysis plan was presented explaining the continuous process improvement practices. This plan states that Missouri Care intends to present evidence that they have achieved improvement in members' oral health which will be measured by each years' HEDIS rate. They will use a quarterly HEDIS-like methodology, added during HY 2015, to measure the effectiveness of current interventions during the study year.
6.6 Were qualified staff and personnel used to collect the data?	**X** Met __Partially Met __Not Met __Unable to Determine	All staff involved are identified. Their roles in the PIP are explained.
Project Leader Name: Karen Einspahr Title: QI Project Manager Role: Oversight of data analysis and tracking results. • Other team members: Names/Roles: Other team members: Chief Medical Officer: Justin R. Cramer, MD, MBA, FAAFP	Totals	**6** Met _____Partially Met _____Not Met _____UTD

• Director, Quality Improvement: Mark Kapp, MBA, BSN, RN, CPHQ • *Sr. Manager, Marketing & Community Relations: Edward Williams* • Manager, Quality Improvement: Erin Dinkel BSN, RN • Project Manager, Quality Improvement: Vicki Mertz, MA WellCare quality and analytics personnel manage data validation, integrity, quality reporting, and oversee technical analysts. This includes trend reporting, data modeling, coding, report design, statistical analyses and queries, data mining, and program evaluation. HEDIS rates are collected and calculated using Inovalon NCQA certified software.		
Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**X** Met __Partially Met __Not Met __Unable to Determine	The member intervention states ..." will maintain successful collaboration with DentaQuest …." This is a new intervention based on the date of implementation. Provider interventions include descriptions of the programs named, and an explanation of how/when these were implemented. They also include how these interventions contributed to any success achieved in getting more members to ADVs would be helpful. In the previous review, the PIP submission included 9 interventions that were planned/implemented during 2016. During the on-site, it was learned that these were under discussion, but were not implemented after the study and review.
Describe Intervention(s): **Member**: 1) Maintaining a successful collaboration with DentaQuest to utilize the Smiling Stork program, for educational purposes. **Providers**: 1)Housing Authority Partnership 2)Partnership with Affinia 3)Continued development of the dental home pilot project	Totals	__1__ Met ___Partially Met _____Not Met _____UTD

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The over-arching explanation of the data for this PIP is described in accordance with the data analysis plan. The analysis described the data presented, and how the PIP has contributed to improved HEDIS rates since its inception.
This Element is "Not Met" if study is complete and there is no indication of a data analysis plan (see step 6.5)		
8.2 Were the PIP results and findings presented accurately and clearly?	**X** Met __Partially Met __Not Met __Not Applicable __Unable to Determine	In several places throughout the narrative, Missouri Care makes the statement – regarding a decline in rates for the Western Region in HY 2016. The MCHP multi-disciplinary team found that "after further review, no root cause was identified." No theory about why the interventions were ineffective was included. In HY 2017 the Western Region showed improvement. The Eastern Region showed a slight decline. The same team reviewed this; and their conclusion was that the Region was impacted by having fewer dental providers than the Western or Central regions.
Are tables and figures labeled? **xx** yes __no Are they labeled clearly & accurately? **xx** yes ___no		
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	__Met **X** Partially Met __Not Met __Not Applicable __Unable to Determine	A discussion of the data included is presented. However, there is no analysis of what factors influenced change and why. A barrier analysis is presented. These are the same barriers presented in at least the last two years. In CY 2016, one additional member barrier, and one additional provider barrier was included. None of the previous barriers were eliminated. Some of these barriers should be resolved if the PIP is having a positive effect. If little or no change is identified, should the types or focus of interventions be re-examined? In previous PIP submissions, a list of system (MCHP) barriers was included. Have these been resolved? If so, some explanation of this success should be included.
Indicate the time periods of measurements: Calculated annually. Indicate statistical analysis used: The statistical analysis used is upper and lower confidence intervals. Indicate statistical significance level or confidence level if available/known: _____99% xx 95% ___Unable to determine		

8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and any follow-up activities?	**X** Met __ Partially Met __Not Met __Not Applicable __Unable to Determine	There is a discussion of why there has been a decline in the Eastern Region. The factors identified included the loss of two large provider groups, and mobile dentistry van that was not sending dental claims or using approved codes. The analysis states that "further investigation is currently being conducted." Missouri Care states that the GeoAccess survey did not indicate a gap in care of the Eastern dental network, even though they state that the number of dentists available is smaller than those in the Central and Western Regions. Missouri Care concludes that the interventions in place are producing positive outcomes, so that they will continue. The changes in the aggregate rates are: HY 2015 – 45.74%; HY 2016 – 46.60%; and HY 2017 – 46.97%. The MCHP rates are increasing. However, the improvement is 1.23 percentage points in the last 2 years. This does not meet the goal of 3% per year, and leaves questions about the true effectiveness of the interventions in place. Follow-up activities and HY 2018 interventions are included. The narrative states that "An opportunity was identified for Case Managers to educate members that are actively engaged, on their annual dental benefits, as well as prevention." This opportunity is integrated in the HY 2018 interventions.
Limitations described: Loss of provider networks, and mobile dentistry units that do not submit correct billing. Conclusions regarding the success of the interpretation: Missouri Care believes their multi-dimensional approach has an overall positive impact on improved member services Recommendations for follow-up: A list of planned interventions for 2017 was presented to continue improvement.	Totals	**3** Met **1** Partially Met _____Not Met ____Not Applicable _____UTD

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	X Met __Partially Met __Not Met __Not Applicable __Unable to Determine	The methodology regarding the sources of data, members examined, and tools used have remained the same since the inception of this PIP. These questions are answered in the narrative provided.
Ask: Were the same sources of data used? Did the use the same method of data collection? Were the same participants examined? Did they utilize the same measurement tools?		Yes.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	X Met __Partially Met __Not Met __Not Applicable __Unable to Determine	Missouri Care asserts that there has been overall improvement in their HEDIS rate. They have only obtained a 6.96% increase from the year they used as baseline (HEDIS 2013 – 43.91%) through HEDIS 2017 (46.97%). The overall improvement through this period should be 12% to meet the stated goal of a 3% increase per year.
Was there: __xx__ Increase _____Decrease Statistical significance ___yes __xx__ no Clinical significance __xx__ yes ___no		This has varied from year to year, but overall has shown an increase in their HEDIS ADV rates.
9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	X Met __Partially Met __Not Met __Not Applicable __Unable to Determine	Missouri Care ties their multi-interventional approach to the improvement that has been achieved. However, the aggregate improvement has not reached the stated goals. They have presented some analysis of how their interventions had a positive effect. It is not possible, with the information provided, to assess which interventions were positive and those that were not. However, due to the overall upward trend, it may be assumed that the interventions did have a positive impact on Missouri Care's ADV rates.
Degree to which the intervention was the reason for change ___No relevance __xx__Small ___ Fair ___High		

9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	__Met __Partially Met __Not Met **X** Not Applicable __Unable to Determine	Since the overall improvement has not yet reached the goal set by the State and the Region, the ability to complete this level of analysis remains not applicable.
_____Weak __xx__Moderate _____Strong	Totals	__**3**__Met ____ Partially Met _____Not Met __**1**__Not Applicable _____UTD
Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	__ Met __ Partially Met ___Not Met **X** Not Applicable __ Unable to Determine	There is no enough positive improvement to make this assessment yet.
	Total	_____Met _____Partially Met _____Not Met __1__ Not Applicable _____UTD
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	Comments
Were the initial study findings verified upon repeat measurement?		

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.

Conclusions:
The foundation of this PIP is sound and well-planned. THE EQRO has questions about the number of, and impact of the interventions shared during the initial review. The goals achieved for HEDIS 2017 were clear and understandable. They continue to implement new interventions. The narrative indicates how Missouri Care tracks and trends the outcomes of their initiatives. The narrative states that they use the quarterly HEDIS-Like data to analyze if current interventions are producing positive outcomes. The MCHP has used the PIP process as a method to obtain improved performance and is committed to continuing these initiatives. Although the ADV HEDIS rates have improved, they have not yet met their yearly goal of a 3% increase.

Recommendations:
1. Continue enhancing narrative that explains outcomes achieved. Provide details of how the interventions contributed to any improvement achieved.
2. If any downward trend occurs, explain it. A study, or specific interventions, can fail to produce positive results. Explain why an intervention may have failed to produce desired results.
3. Include follow-up plans that correct any problems.
4. Examine the effectiveness of the interventions currently in place, and consider trying something new and different to achieve PIP goals.

Check one:
☐ High confidence in reported Plan PIP results
X Confidence in reported Plan PIP results
☐ Low confidence in reported Plan PIP results
☐ Reported Plan PIP results not credible
☐ Unable to determine – the PIP is new and has produced no results

CONCLUSIONS

QUALITY OF CARE

The issue of quality was a primary focus of the PIPs undertaken by Missouri Care. Quality healthcare and improved quality of life for MCHP members were addressed. Implementing measures to ensure that members obtain required childhood immunizations enhances preventive services. The PIPs sought to improve healthcare by focusing on aspects of care that may have been neglected, leading to negative outcomes. The MCHP provided opportunities for preventive dental care enhancing the quality of services received by members. They planned to incorporate effective interventions into normal daily operations when data indicated positive outcomes. Undertaking performance improvement projects that will develop into enhanced service programs for members indicates a commitment to quality service delivery.

ACCESS TO CARE

The study topics presented in these PIPs addressed issues that will create improved services and enhanced access to care for the Missouri Care members. The clinical PIP stresses the need for members to obtain childhood immunizations, and includes interventions that expand access to services. These included partnering with FQHCs and other community health providers to identify members in need of this service, and to provide immunizations in an environment most accessible to members. Missouri Care worked with their dental subcontractor, their providers, and members to create new opportunities to access dental services. The statistics from CY 2015 and CY 2016 were generally positive, indicating that the MCHP corrected data issues and are reporting dental visit data correctly. Additionally, Missouri Care has put activities in place that are community based. These activities focus on providing dental care in settings that are easy for members to access.

TIMELINESS OF CARE

The clinical performance improvement project implemented strategies to educating members and providers of the importance of obtaining childhood immunizations within the recommended timeframes. There is continued room for improvement to make this PIP truly effective, and the MCHP is working on new interventions to meet their goals. The MCHP worked with providers and members to ensure that there was access to timely dental appointments. By developing opportunities to provide dental care in community based settings, Missouri Care is improving the members' ability to obtain dental visits.

RECOMMENDATIONS

1. Update information contained in the study topic to ensure continued relevance of the PIP. Identify what has been achieved and what remains to be accomplished to reach the goals of the study.
2. Continue to utilize the protocols to develop and evaluate performance improvement studies. The quality of the clinical studies submitted continues to improve.
3. Recognize the need to implement new interventions yearly, based on the analysis of which interventions were successful and those that failed to provide positive outcomes.
4. Work towards enhanced narrative that explains the outcomes; and include analysis of how the interventions contributed to improvement.
5. When a downward trend occurs, explain it. A study, or specific interventions, can fail to produce positive results. Explain why an intervention may have failed to produce desired results.
6. Continue the process of looking at MCHP statistics and data to analyze the best use of resources in creating performance improvement initiatives. Complete a true analysis to adequately report the outcomes achieved.

8.2 Validation of Performance Measures

Methods

Objectives, technical methods, and procedures are described separately. This section describes the documents and data reviewed for the Validation of Performance Measures for Missouri Care. Missouri Care submitted the requested documents on the due date of March 7, 2017. The EQRO reviewed documentation between March 7, 2017 and June 26, 2017. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation. The MCHP could provide corrected data to ensure the calculation of all measures; this data was received by the EQRO on November 6, 2017; and the information contained in this section reflects the revised data.

Document Review

The following are the documents reviewed by the EQRO:

- The NCQA RoadMap (QSI Final Certification)
- WellCare Missouri 1624 FAR 2016
- WELL IS-HD Compliance Tool 2016
- Missouri Care's HEDIS Data Entry Training Manual
- Missouri Care's Policies pertaining to HEDIS rate calculation and reporting

Data files were submitted by Missouri Care for review by the EQRO; these included Statewide and regional files for Prenatal and Postpartum Care (PPC), and regional files for the Emergency Department Visits (EDV) and Emergency Department Utilization (EDU) measures audited.

Interviews

The EQRO conducted on-site interviews in Columbia, MO on Monday, June 26, 2017 with the Missouri Care staff that were responsible for the process of calculating the HEDIS 2016 performance measures and the Measures Reported to MO HealthNet for Data Year 2015. The objective of the visit was to verify the methods and processes behind the calculation of the HEDIS 2016 performance measures and the measures reported to MO HealthNet in the Healthcare Data Quality Template report.

FINDINGS

Two of the measures being reviewed (Emergency Department Visits and Emergency Department Utilization) were calculated using the Administrative method; and the third measure (Prenatal and Postpartum Care) was calculated using the Hybrid method.
The MCHP reported a PPC rate of 77.51% for Prenatal Care and 61.72% for Postpartum Care; and these measures were lower than the statewide rate for all MCHPs (78.17% Prenatal and 62.73% Postpartum). These rates were also lower than the National Medicaid HMO Average for these measures (82.43% for Prenatal and 61,79% for Postpartum). This is the first year since 2006 that this measure has been validated by the ERQO.

This was the second year that the EQRO was requested to validate the information provided by the MCHPs on the Healthcare Data Quality Template. The measures that the EQRO validated from this report were Emergency Department Visits (EDV) and Emergency Department Utilization (EDU). Both measures are stratified by presenting diagnosis (Behavioral Health; Medical; or Substance Abuse). These are modified measures for the 2016 HEDIS Technical Specifications for Ambulatory Care (AMB), Mental Health Utilization (MPT), and Identification of Alcohol and Other Drug Services (IAD).

MO HealthNet requested that EQRO recalculate these measures and compare the calculations to the data submitted on the June 30 report. The objectives included determining if each MCHP was calculating the measure in the same fashion and determining if the MCHP could reproduce and provide the data used to calculate these modified HEDIS measures. Missouri Care's original submission was considered invalid as the data provided did not contain the date of birth, but contained inpatient admission dates which should not be present. Missouri Care resubmitted the data in November 2017 with the dates of birth and was asked to remove all inpatient admission dates that were not true inpatient stays. The EQRO revalidated the submission and found it to be invalid. The EQRO was unable to reproduce the numbers that Missouri Care reported on the Healthcare Data Quality Template.

Data Integration and Control

The information systems management policies and procedures for rate calculation were evaluated as consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing, and reporting. For

the PPC measure, Missouri Care was found to meet all the criteria for producing complete and accurate data. They were found to be unable to produce complete and accurate data for the Healthcare Data Quality Template data.

Documentation of Data and Processes

Although Missouri Care uses a proprietary software package to calculate HEDIS measure rates, adequate documentation of this software and its processes was provided to the EQRO for review. The data and processes used for the calculation of measures were acceptable for the HEDIS measure PPC.

Processes Used to Produce Denominators

Missouri Care met all criteria for the processes employed to produce the denominators for the PPC measure. This involves the selection of eligible members for the services being measured. Denominators in the final data files for both the EDU and EDV measure were inconsistent with those reported for the measures validated. For the 2016 review, Missouri Care provided an enrollment file for each of the MCHP regions for the EDV and EDU measures. The total number of records contained in the three EDV enrollment files was 55,197, although the MCHP reported 114,706 eligible members to MO HealthNet. All members were unique; and the dates of birth ranges were valid.

Processes Used to Produce Numerators

Two of the three measures were calculated using the Administrative method (EDV and EDU). The third measure (PPC) was calculated using the Hybrid method. The PPC measure included the appropriate data ranges for the qualifying events (e.g., prenatal visits; delivery date). The EDV and EDU measures included the member's date of birth and service date. Appropriate procedures were followed for the sampling of records for medical record reviews.

Missouri Care provided three numerator files (one for each MCHP region), and the total number of records contained in these files was 95,802. The EQRO could validate 63,374 EDV-Medical hits from these files; therefore, the MCHP's 93,762 reported hits are an overestimate of 26.49%. There were 1,408 Missouri Care submitted records that contained an "Inpatient Admission Date" and 30,358 records that did not contain a service code or procedure code to validate that the service was an approved ER service.

Although Missouri Care reported a total of 1,394 EDV-Behavioral Health hits, the MCHP supplied three files that contained a total of 733 records containing a mental health diagnosis. Of these 733 records, 153 contained an inpatient admit date; and these records could not be validated, as the technical specifications for the Healthcare Data Quality Report instructs the MCHP to "only include observation stays that do not result in an inpatient stay." Additionally, 197 records submitted by Missouri Care did not contain a service code or procedure code. The data submitted to the EQRO when recalculated does not produce the number of hits reported to MO HealthNet; and therefore, the EQRO concludes that the Healthcare Data Quality Report does not represent an accurate representation of the number of Missouri Care Emergency Department visits that were supplied for members with a behavioral health diagnoses.

Although Missouri Care reported a total of 335 EDV-Substance Abuse hits, and the MCHP supplied three files that contained a total of only 40 records with a Chemical Dependency diagnosis. Of these 40 records, three contained an inpatient admit date; and these records could not be validated, as the technical specifications for the Healthcare Data Quality Report instructs the MCHP to "only include observation stays that do not result in an inpatient stay." Additionally, 16 records submitted by Missouri Care did not contain a service code or procedure code.

Missouri Care provided three numerator files (one for each MCHP region), and the total number of records contained in these files was 49,184. The EQRO could validate 30,722 EDU-Medical hits from these files. There were 742 Missouri Care submitted records that contained an "Inpatient Admission Date" and 17,186 records that did not contain a service code or procedure code to validate that the service was an approved ER service.

In 2016, a difference of 825 records was found by the EQRO for EDU-Behavioral Health hits. This was due to records that contained inpatient admission dates and 202 records that did not contain a service code or procedure code. Additionally, for the EDU-Substance Abuse measure, the 2016 Missouri Care submission contained a difference of 267 records from what was provided to MO HealthNet in the Healthcare Data Quality Template report. This difference was due to records that contained inpatient admission dates and 15 records that did not contain a service code or procedure code.

Sampling Procedures for Hybrid Methods

The Hybrid Method was used for the Prenatal and Postpartum measure: CMS Protocol Attachment XII, and Impact of Medical Record Review Findings and Attachment XV. Sampling Validation Findings were completed for this measure. Missouri Care was compliant with all specifications for sampling processes.

Submission of Measures to the State

Missouri Care submitted the Data Submission Tool (DST) for the HEDIS measure to the SPHA (the Missouri Department of Health and Senior Services) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and MO HealthNet Quality Improvement Strategy. Missouri Care submitted data as requested for the Healthcare Quality Data Template report; however, due to the discrepancies found in the data submitted to the EQRO that was to validate the numbers submitted in that report, the EQRO is uncertain of the accuracy of the numbers contained in the MO HealthNet report.

Determination of Validation Findings and Calculation of Bias

As shown in Table 29, no bias was found for the PPC measure; however, bias was observed in both the EDV and EDU measures.

Table 29 - Estimate of Bias in Reporting of Missouri Care HEDIS 2015 and 2016 Measures.

Measure	Estimate of Bias 2015	Direction of Estimate	Estimate of Bias 2016	Direction of Estimate
Prenatal and Postpartum Care (PPC)	Measure Not validated	N/A	None	N/A
Emergency Department Visits - Medical	0.02%	Overestimate	26.49%	Overestimate
Emergency Department Visits – Behavioral Health	0.01%	Overestimate	0.89%	Overestimate
Emergency Department Visits – Substance Abuse	0.01%	Overestimate	0.27%	Overestimate
Emergency Department Utilization - Medical	0.04%	Underestimate	14.86%	Overestimate
Emergency Department Utilization – Behavioral Health	0.01%	Overestimate	0.72%	Overestimate
Emergency Department Utilization – Substance Abuse	No bias	N/A	0.22%	Overestimate

Source: BHC, Inc., 2015 and 2016 External Quality Review Performance Measure Validation.

Final Audit Rating

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure (see Table 30). The rate for the Prenatal and Postpartum Care measure showed no bias and was therefore deemed Fully Compliant. The Emergency Department Visits and Emergency Department Utilization measures were found to be overestimated, and were considered invalid.

Table 30 - Final Audit Rating for Missouri Care Performance Measures.

Measure	Final Audit Rating
Childhood Immunization Status	Fully Compliant
Emergency Department Visits	Not Valid
Emergency Department Utilization	Not Valid

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCHP. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No Managed Care Members qualified for the measure.

Conclusions

Three rates were validated for the MCHP. The Prenatal and Postpartum Care rates were **lower** than the average for all MCHPs; and the Emergency Department Visits measure and the Emergency Department Utilization rate were rated not valid. The ratings were not valid due to the MCHP's inaccurate data submission.

Quality of Care

Missouri Care's calculation of the Emergency Department Utilization measure was not valid due to missing and inaccurate data. This measure serves to provide a count of the individual number of members who access the ED for various issues, over the course of the measurement year. This measure provides further detail to the reason for the ED visit, categorizing it as Medical, Behavioral Health, or Substance Abuse. This information is useful for the MCHPs to determine if the ED is being utilized properly by its members.

Access to Care

The Emergency Department Visit measure was not valid due to missing and inaccurate data. This measure is an Access to Care measure as it measures the number of ED visits recorded for the MCHP.

Timeliness of Care

The MCHP's calculation of the HEDIS 2016 Prenatal and Postpartum Care measure was fully compliant. This measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received. The MCHP's reported rate for the Prenatal and Postpartum measures were **lower** than the average for all MCHPs. This rate has not been audited by the EQRO since 2006.

Missouri Care members are receiving less timely Prenatal and Postpartum care than that of other MO HealthNet Managed Care members. Additionally, both rates are **lower** than both the National Medicaid HMO averages for this measure. The MCHP's members are receiving Prenatal and Postpartum care in a manner that is **less** timely than the average Medicaid member across the nation.

Recommendations

1. Continue to conduct and document statistical comparisons on rates from year to year.
2. Participate in training of MCHP staff involved in the oversight of coordination of performance measure calculation.
3. Continue to perform hybrid measurement on those measures that are available for this method of calculation.
4. Provide data in the format and file in which it is requested.
5. Consult the EQRO regarding any uncertainties regarding the data that is required.
6. Ensure the accuracy of data submissions by including all requested data elements. The EQRO must validate that the MCHP's calculations are correct; and, when data is missing, this validation cannot occur.

8.3 MCHP Compliance with Managed Care Regulations

METHODS

Missouri Care was subject to a full compliance audit during this on-site review. The content of this 2016 calendar year audit will include follow-up to all components of the Quality Standards as defined in 42 CFR 438 that were found to be lacking during the 2015 review. Evaluation of these components included review of:

- Defined organizational structure with corresponding committee minutes
- Policies and Procedures
- Organizational protocols
- Print materials available to members and providers
- Report results
- Staff interviews

The Team utilized an administrative review tool which was developed based on the CMS Protocol Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations (Compliance Protocol). The evaluation included review of Missouri Care's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, Missouri Care was evaluated on the timeliness, access, and quality of care provided. This report incorporates a discussion of the MCHP's strengths and weaknesses with recommendations for improvement to enhance overall performance and compliance with standards.

The EQRO rating scale remains as it was during the last evaluation period.

M = Met

Documentation supports that all components were implemented, reviewed, revised, and/or further developed.

PM = Partially Met

Documentation supports some but not all components were present.

N = Not Met

No documentation found to substantiate this component.

N/A = Not Applicable.

Component is not applicable to the focus of the evaluation. N/A scores will be adjusted for the scoring denominators and numerators.

A summary for compliance for all evaluated Quality Standards is included in Table 31.

Table 31 - Missouri Care Compliance Ratings for Compliance Review Years (2014-2016).

Measure	2014	2015	2016
Enrollee Rights and Protections	100%	100%	100%
Access and Availability	82.35%	64.71%	70.59%
Structure and Operations	100%	100%	100%
Measurement and Improvement	90.91%	90.91%	81.82%
Grievance Systems	100%	100%	100%

Source: BHC, Inc., 2014 - 2016 External Quality Review Compliance Validation.

The review of Quality Standards was completed using a Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

FINDINGS

Enrollee Rights and Protections

The area of Enrollee Rights and Protections addresses 13 standards. For the 2016 review, Missouri Care was rated by the review team to have met all 13 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2014 and 2015. The rating for Enrollee Rights and Protections (100%) reflects that the MCHP complied with the submission and approval of all policy and procedures to MO HealthNet. All practice observed

at the on-site review indicated that the MCHP appears to be fully compliant with MO HealthNet Managed Care Contract requirements and federal regulations in this area.

Access Standards

The area of Access and Availability addresses 17 standards. For the 2015 review, Missouri Care was rated by the review team to have met 12 standards. This is an overall rating of 70.59% which is **higher** than their 2015 rating of 64.71%, but still **lower** than the 76.47% rating received in 2014.

The rating in this area is mostly attributable to the Case Management record review and the provider availability survey performed by the EQRO. In the Case Management review, the EQRO found that Missouri Care did not introduce case management; declined in including assessments and care plans, and including or informing the PCP about the care plan. Improvements were observed in lead case management. In the provider availability survey, the EQRO found that most of the providers listed on the MCHP's website were not taking new patients.

Missouri Care submitted required policy and procedures to MO HealthNet for their approval. In reviewing records and interviewing staff, the EQRO observed transition planning at case closure and providing care coordination improved over what was observed during the 2015 review.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2016 review, Missouri Care was rated by the review team to have met all 10 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2014 and 2015. The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the eighth year. The MCHP submitted all required policy for approval; and all practice observed at the time of the on-site review indicated compliance in this area. All credentialing policy and practice was in place. All disenrollment policy was complete; and all subcontractor requirements were met.

During the 2011 Calendar Year, Missouri Care became NCQA accredited and continued to follow NCQA standards regarding credentialing. All credentialing performed by Missouri Care met NCQA standards and complies with federal and state regulations, and MO HealthNet contract requirements. Re-credentialing is completed at three-year intervals, and delegated entities are monitored annually. State and federal sanctions are monitored monthly using the HHS OIG/OPM (Office of Inspector General/Office of Personnel Management) web site.

Measurement and Improvement

The area of Measurement and Improvement addresses 12 standards. For the 2016 review, Missouri Care was rated by the review team to have met 9 standards, one standard was rated as "Partially Met;" one was rated as "Not Met;" and one standard was found to be "Not Applicable." This is an overall rating of 81.82% which is **lower** than the 90.91% rating received in 2014 and 2015.

Missouri Care continues to operate a Quality Management Oversight Committee. The goal of this group was to provide oversight of all operations and MCHP initiatives.

Missouri Care did submit two Performance Improvement Projects (PIPs), which included enough information to complete validation. These PIPs have areas that need improvement. The PIPs were well-constructed and responded to areas of member services in need of improvement. However, the clinical PIP received a 66.67% rating due to insufficient improvement strategies and data analysis issues.

All Performance Measurement data and medical records requested were submitted for validation within requested timeframes. However, the MCHP submitted data that contained inaccurate and missing fields therefore two of the Performance Measures were rated as Not Valid.

Grievance Systems

Grievance Systems address 18 standards. For the 2016 review, Missouri Care was rated by the review team to have met all 18 standards. This is an overall rating of 100% compliance, which is consistent with the 100% rating received in 2014 and 2015.

Ratings for compliance with the Grievance Systems regulations (100%) indicates that the MCHP completed the requirements regarding policy and practice. The EQRO sampled and reviewed some Grievance and Appeals records during the on-site review and found that they met all required timeframes and documentation.

Conclusions

Missouri Care continues to maintain compliance in all areas of policy, procedure, and practice required by the MO HealthNet Managed Care contract and the federal regulations. The MCHP utilizes a proactive approach to identifying issues discussed in previous External Quality Reviews, internal monitoring, and its Quality Improvement program to ensure that required written materials were submitted to MO HealthNet in a timely and efficient manner.

However, a few issues were identified during this year's review, including:

- Failure to approve or report on face-to-face contacts in case management files;
- Not providing case management records as requested;
- Provider availability issues regarding website accuracy and accepting new patients; and
- Providing performance measurement data that contained inaccurate and missing fields.

Quality of Care

Quality of care is a priority for Missouri Care. Their attention to internal and external problem solving, supporting and monitoring providers, and participation in community initiatives are evidence of the commitment to quality healthcare. They are making a concerted effort to extend this approach to all three MO HealthNet Regions. Missouri Care completed all policy requirements and has put processes in place to ensure that procedures and practices follow approved policy requirements. A commitment to obtaining quality service for members is evident in interviews with MCHP staff who express enthusiasm for their roles in producing sound healthcare for their members.

Access to Care

Missouri Care has made concerted efforts to ensure that members throughout their MO HealthNet Regions have adequate access to care. The MCHP has participated in community events to promote preventive care and to ensure that members are aware of available services.

The MCHP exhibits an awareness and commitment to resolving issues that are barriers to member services.

However, the accuracy of the Missouri Care's website listings for providers needs attention. During a website accuracy and secret shopper survey the EQRO conducted for MO HealthNet, the EQRO found significant issues with the accuracy of provider information and availability on the MCHP's website. Further information regarding the Website Accuracy Survey may be found at http://dss.mo.gov/mhd/mc/pdf/health-plan-website-accuracy-new-patient-acceptance-rates-report.pdf.

Timeliness of Care

Missouri Care has developed procedures to ensure that policy is submitted in a timely manner and that all tracking tools are up-to-date. They are utilizing greatly improved case management software and systems tools to have the most accurate and up-to-date information available on members to support them in obtaining appropriate healthcare services in a timely manner. The MCHP has engaged in activities to ensure that organizational processes support the delivery of timely and quality healthcare.

Recommendations

1. Make every effort to supply the EQRO with all relevant information for every case file, grievance file, policy, or procedure requested.
2. Ensure that all relevant data is checked prior to submission to any auditing agency, and make regular test runs of data to identify any issues as early as possible.
3. Continue to develop and improve the multi-disciplinary approach to working with members that have complex health care issues.
4. Enhance provider websites and ensure accuracy of provider listings.
5. Improve adherence to case management policy including: providing face-to-face contacts; and informing PCPs regarding care plans.